Administrative Services – Risk Management
721 Cliff Drive, Santa Barbara, CA 93109-2394
(805) 965-0581 / FAX (805) 963-7222

APPENDIX A

SAMPLE FORMS

Authorization for Disclosure
Consent for HBV/HCV Antigens, HIV Antibody
Documentation of Staff Education
Employees Eligible for Hepatitis-B Vaccination
Hepatitis-A Consent
Hepatitis-B Consent
Hepatitis-B Declination
Hepatitis-B Titer
Hepatitis-B Vaccine Immunization Record
Hepatitis-B Vaccine Series
Post-Exposure Investigation
Post-Exposure Report
Post-Exposure Procedure
Sharps Injury Log
Source Individual Consent
Training Sign-In
Training Health-Tech
Vaccine Requests

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AUTHORIZATION FOR DISCLOSURE

This authorization and consent for use or disclosure of the results of a blood test to detect the presence of antibodies to the Human Immunodeficiency Virus (HIV) or Hepatitis-B Virus (HBV) or Hepatitis-C (HCV) is being requested of you to comply with the terms of the Confidentiality of Medical Information Act, Civil Code section 56 et seq., the Information Practices Act, Civil Code section 1798 et seq., Health and Safety Code section 199.21 (g), Education Code section 49076 where applicable, and Article I, section 1 of the California Constitution.

I, ________________________________, hereby authorize:

____ and to
(Title or Name of Designated Representative of School District to Which Disclosure of Medical Information Was Made)

____
(Health Care Provider)

To furnish to: ____
(Name or Title of Person to Receive Information.)

the results of my blood test to determine the presence of HIV antibodies or the Hepatitis B Virus.

The person(s) receiving this information may use the information for any purpose, subject only to the following limitations: ____
____
____

This authorization and consent shall be come effective immediately, and shall remain in effect indefinitely, or until: Date _______/________/_________

I understand the person(s) identified above, receiving the information identified above, may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

I further understand that I have a right to receive a copy of this authorization upon my request.

_________________________ Date

_________________________ Signature

_________________________ Printed Name

_________________________ Parent/Guardian's Signature if Minor

_________________________ Printed Parent/Guardian's Name

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CONSENT FOR HBV /HCV ANTIGENS AND HIV ANTIBODY BLOOD TEST

I have been requested because of a recent incident to have my blood tested for HBV / HCV antigens and HIV antibodies. I understand that an individual has been exposed and may be at risk for Hepatitis B (HBV), Hepatitis C (HCV) or AIDS virus (HIV) infection.

I understand that the results of this blood test will only be released to those health care practitioners directly responsible for my care and treatment and the exposed employee.

I have been informed that if I have any questions regarding the nature of the blood test, it's expected benefits, its risks, and alternative tests, I may ask those questions before I decide to consent to the blood test.

I will have the blood test as soon as feasible in order to determine HBV / HCV or HIV infectivity.

________________________________ ________ - ______ - ____________

Printed Name Social Security #

____

Address City State Zip

( ) ______________________________________

Phone

______________________________ ______________________________

Signature Witness

_______/_____/_______ _______/_____/_______

Date Date

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EXPOSURE CONTROL PLAN
BLOODBORNE PATHOGENS

DOCUMENTATION OF STAFF EDUCATION

Employee Name________________________ Job Title_________________ Department _________________

Date of Training ____________________ Instructor's Name ____

TOPIC	Reviewed (x)
1. Epidemiology/Symptoms/Modes of transmission of HIV / HBV / HCV infections	_____
2. The Infection Control Program and Manual, including: a. Hand washing b. Universal Precautions c. Isolation techniques	_____
3. The exposure control program	_____
4. Recognition of activities that can cause exposure	_____
5. How to prevent/reduce exposure: Engineering Controls Work Practices Personal protective equipment: proper use, removal, handling, decontamination, disposal, storage locations, how to select protective equipment	_____
6. Hepatitis B Vaccine - efficacy, safety, benefits, adverse reactions	_____
7. Emergencies - persons to contact and actions to take	_____
8. Exposure incidents - incident report, medical follow-up and counseling at no cost	_____
9. Labels, signs, and color coding	_____
10. Infections, spills - cleanup and reporting	_____
11. Infectious waste handling	_____
12. Handouts given	_____

The above has been reviewed with me, I am satisfied that I have a good understanding of its contents, and I had ample opportunity to have my questions answered.

______________________________ _______/_______/_______
Employee Signature Date

The above has been reviewed with the employee and I certify that at the conclusion of the training the employee had an adequate understanding of the program's contents.

______________________________ ________/_______/_______
Instructor's Signature Date

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EMPLOYEES ELIGIBLE FOR HEPATITIS-B VACCINATION

EMPLOYEE	DEPT.	CONSENT/ DECLINE	TRAINING DATE	INOCULATION			COMMENTS
				#1	#2	#3	

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Hepatitis-A Consent

The MedCenter
Santa Barbara CA
2945 State Street
(805) 6827411

_______________________________ is an employee at Santa Barbara City College. He/she is authorized for Hepatitis A vaccine series. Please forward the vaccine record via FAX to Risk Management, Attention: Steven Lewis, Risk Manager.
Please bill invoice to Steven Lewis, Administrative Services.

________________________________ _________________
Risk Manager Signature Date

I authorize the release of the Hepatitis A vaccine records to Santa Barbara City College Student Health Services. I further give permission for the medical care providers at the MedCenter to confer with the Risk Manager, Administrative Services regarding the records.

________________________________ _________________
Employee Signature Date

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Hepatitis-B Vaccine Consent

Hepatitis-B is caused by the Hepatitis-B virus which is transmitted by coming in contact with contaminated blood or body fluids through a needle puncture, a break in the skin or contact with mucosal surfaces (eyes, mouth, genital tract). The lifetime risk of Hepatitis B is about 5% for the general population. Health care workers however, have an increased risk (up to 20% over a lifetime) because of frequent blood exposure. Most people with Hepatitis B recover completely, but 1-2% die and 5-10% become chronic carriers of the virus. Chronic carriers may have no symptoms or may have chronic liver disease leading to cirrhosis. An association has also been demonstrated between Hepatitis B carriers and liver cancer.

Hepatitis-B vaccine (Recombivax-HB) is a non-infectious vaccine derived from Hepatitis-B antigens produced in yeast cells. The current vaccine is free of association with human blood or blood products. Tests of the vaccine in humans have demonstrated development of protective antibodies in 90% of those vaccinated with the full series of three doses. ***The vaccine series consists of the three injections given at 0, 1 and 6-month intervals.*** The duration of the antibody protection is unknown. As with all immunizations there is no guarantee that immunity will develop.

No serious side effects have been associated with the vaccine, however, as with any drug, there is a slight possibility of an allergic reaction. Mild soreness and redness at the injection site may occur. Fever, nausea, rash, headache, fatigue and joint pain have been reported.

Recombivax-HB is contraindicated in the presence of hypersensitivity to yeast. Any serious active infection is reason for delaying use of the vaccine except when withholding the vaccine entails a greater risk. The vaccine will be given to pregnant women only if clearly needed and as recommended by her physician.

I have been trained regarding bloodborne pathogens and possible exposure to Hepatitis-B. I have read the above statement about Hepatitis-B and the vaccine. I understand the benefits and risks involved. ***I understand that I must have all three doses of the vaccine to confer immunity.*** I acknowledge that I have 30 days to complete the first injection or sign the Hepatitis-B Declination Form. If after 30 days I have not received the first injection or have not signed the Hepatitis-B Declination Form, my supervisor will be notified.

I request that the Hepatitis-B vaccine series be given to me.

___________________________________ ______________________
Print Name Department

___________________________________ ______________________
Signature Date

___________________________________ ______________________
Witness Date

Please return completed form to Risk Manager, Administrative Services

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Hepatitis B Vaccination Declination Form

___________________________________ ________- ______- ________
Employee Name Social Security #

____
Department

I understand that due to my occupational exposure to blood or other potential infectious material, I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine, at no charge to myself. However, I decline the Hepatitis B vaccine at this time. I understand that by declining this vaccine I continue to be at risk of acquiring Hepatitis B, a serious disease. If, in the future, I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with the Hepatitis B vaccine, I can request and receive the vaccination series at no charge to me.

___________ I have received the Hepatitis B vaccine series or have had Hepatitis B.
Initial

Dates of vaccine series: ____________ __________________ _________________

Other Comments:

____

____

____ ______________________
Employee Signature Date

____ ______________________
Witness Date

Please return this form to Risk Manager, Administrative Services

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HEPATITIS B TITER

The MedCenter, Santa Barbara CA
2945 State Street 682-7411
319 N. Milpas Street 965-3011

___________________________________ is an employee at Santa Barbara City College. By OSHA standards on bloodborne pathogens, he/she is eligible for Hepatitis vaccine series. Before receiving the series this employee has requested a Hepatitis B titer. Please forward the results to Risk Management, Attention: Steve Lewis, Risk Manager.

_________________________________ ________________________
Risk Manager Signature Date

I authorize the release the release of the Hepatitis B titer results to Santa Barbara City College Health Services. I further give permission for the medical care providers at the MedCenter to confer with the Risk Manager, Administrative Services regarding the results.

_________________________________ ________________________
Employee Signature Date

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HEPATITIS B VACCINE SERIES

The MedCenter, Santa Barbara CA
2945 State Street 682-7411
319 N. Milpas Street 965-3011

___________________________________ is an employee at Santa Barbara City College. By OSHA standards on bloodborne pathogens, he/she is eligible for Hepatitis B vaccine series. He/she is unable to attend the scheduled SBCC vaccine clinics and will need to receive the vaccine at the MedCenter. Please forward the vaccine record to Attention: Steve Lewis, Risk Manager.

_________________________________ _________________________
Risk Manager Signature Date

I authorize the release of the Hepatitis B vaccine records to Santa Barbara City College Administrative Services. I further give permission for the medical care providers at the MedCenter to confer with Risk Manager, Administrative Services regarding the records.

_________________________________ _________________________
Employee Signature Date

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BLOODBORNE PATHOGEN POST-EXPOSURE INVESTIGATION FORM

Date of Incident: ______________ Time of Incident: ______: _______ AM / PM

Name of Exposed Employee: ____

Potentially Infectious Materials Involved:

Type: _____________________ Source: ______________________________
(i.e.: blood or OPIM) (i.e.: needle, bandages, bleeding wound)

Exposure Circumstances: ____
____
____

Cause of Incident: ____
____

Personal Protective Equipment Being Used: ______________________________
____

Source Individual Identity: Known ___ Unknown ___

If Known:

1. Consent for blood test obtained Date: _____/_____/_______
   Blood Collected Date: _____/_____/_______

2. Consent not obtained Date: _____/_____/_______

   Verified by: (name) ____
   Medical Professional

   Comment: ____

3. Known HIV positive: Yes ___ No ___
   Known Hepatitis-B positive: Yes ___ No ___
   Known Hepatitis-C positive Yes __ No

4. Results of Source individual's blood test made available to exposed employee:

   Date: _____/_____/________

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BLOODBORNE PATHOGEN POST-EXPOSURE REPORT FORM

Employee Name: ______________________________

Date of Exposure Incident: ________/_______/_______ Time of Incident: _____:_____ AM or PM

____
(Name of Healthcare Provider)

Employee previously vaccinated against HBV infection: Yes:_____ No: _____ Date: _____/_____/______

Description of employee's duties during the exposure incident: ___________________________________
____
____

The route of exposure was:
Needle stick with contaminated needle to : ____

Piercing of skin with contaminated sharp to: ____

Splashing/spraying of blood or other potentially infectious material to: _____________________________

Other: ____

The circumstances under which exposure occurred are (describe): ________________________________
____

Personal protective equipment being used: ____

The source individual is known: _____Yes _____ No

If known, is known to be infected with HBV ________HIV ________HCV _______

Request form for blood testing obtained: _____ Yes _____ No

The following remedial action may minimize the likelihood of future exposure: ______________________
____
____

____ ______/_____/______
Signature of Program Coordinator/Health Services Nurse Date

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BLOODBORNE PATHOGEN POST-EXPOSURE PROCEDURE

Employee: Must report occurrence of an occupational exposure incident to supervisor as soon as possible.
Refer to: Bloodborne Pathogen Post-Exposure Report Form

Description of the sharp that was involved in the incident (if applicable).
Refer to: Sharps Injury Log

SBCC District: Investigate circumstances surrounding the exposure incident.
Refer to: Bloodborne Pathogen Exposure Investigation Form

If appropriate, make immediately available a confidential medical evaluation and follow-up.

Will offer repeat HIV testing to the exposed employee at designated intervals post-exposure. (i.e., 12 weeks and 6 months post exposure.)

Follow-up of the exposed employee shall include counseling, medical evaluation of any acute febrile illness that occurs within 12 weeks post-exposure.

Will use **Post-Exposure Report Form/Checklist** to verify that all steps in the post-exposure process have been taken correctly.

Identified Source Follow-up:

SBCC District: Will seek to obtain consent of identified source.
Refer to: Source Individual Consent Form

Obtain identified source for authorization for disclosure.
Refer to: Authorization For Disclosure Form.

Make medical evaluation and follow-up appointments.

If source individual refuses to sign above consent, District to document refusal.

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Sharps Injury Log

Please complete a Log for each employee exposure incident involving a sharp

Name:________________________________Department_______________________________
Address:______________________City:____________________State:__________Zip Code_____________
Phone: ( ) ______ - ___________ Date of injury: _______/______ / _______
Description of the exposure:

____
____
____
____

Job classification:

- ☐ MD
- ☐ Nurse
- ☐ Facilities
- ☐ Faculty/Staff
- ☐ Student
- ☐ Other

Department/Location:

- ☐ Health Services
- ☐ Classroom
- ☐ General campus
- ☐ Other

Did the exposure incident occur:

- ☐ During use of sharp
- ☐ Disassembling
- ☐ Between steps of a multi-step procedure
- ☐ After use and before disposal of sharp
- ☐ While putting sharp into disposal container
- ☐ Sharp left, inappropriate place (table, bed, etc)
- ☐ Other

Body part:
(check all that apply)

- ☐ Finger
- ☐ Hand
- ☐ Arm
- ☐ Face/Head
- ☐ Torso
- ☐ Leg
- ☐ Other

Identify sharp involved (*if known*)**:**
Injury occurred before or after activation of mechanism ☐ Before ☐ After
Device had protective mechanism ☐ Yes ☐ No ☐ Don't know
Type: ______________________
Brand: ______________________
Model: ______________________
Exposed employee: If sharp had no engineered sharps injury protection, do you have an opinion that such a mechanism could have prevented the injury? ☐ Yes ☐ No
Explain ____
____

Do you have an opinion that any other engineering, administrative or work practice control could have prevented the injury? ☐ Yes ☐ No
Explain: ____
____

Signature of injured: ___________________ Date: _____ /_____ / ______
Signature of recorder: __________________ Date: _____ / _____ / ______

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Sharps Injury Log

Date & Time	Name	Dept.	Position	Location of Incident	Type of Injury	Device Brand Name & Type	How Injury Occurred *	Protective Mechanism? (Yes / No)	Occurred Before, During or After Activation of Mechanism?	Employee Opinion**

* Include: 1. Procedure being performed 2. Body part involved in exposure

** Include: (If sharp had no protection) 1. Employee opinion as to whether protection would have prevented injury 2. Whether any other engineering, administrative, or work practice control could have prevented the injury.

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SOURCE INDIVIDUAL CONSENT FORM

I, _________________________________, have been identified as the source of blood or bodily
Name

fluid involved in an occupational exposure incident at ___________________________________
(Place of exposure)
on ______________________________. Pursuant to Cal/OSHA regulations governing bloodborne pathogens, and the Exposure Control Plan enacted by Santa Barbara City College, I have been requested to consent to the testing of my blood to detect the presence of antibodies to the Human Immunodeficiency Virus (HIV), Hepatitis B Virus (HBV) and Hepatitis C Virus (HCV).

Accordingly:

______ I refuse to grant my consent for such testing.

______ I grant my consent for the testing of my blood and/or bodily fluid in order to ascertain whether the HIV, HBV or HCV is present. My consent is hereby given voluntarily of my own free will. My consent has not been obtained through duress, coercion or pressure.

Dated: ____________________________

____
Signature

____
Printed Name

____
Parent/Guardian's Signature if Minor

____
Printed Parent/Guardian's Name if Minor

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Bloodborne Pathogen Vaccine Request Form

Name ____

Department ____

Job Title ____

Please attach current job description.

Specific job duties that you feel put you at risk of exposure to Hepatitis B and other bloodborne pathogens:

Identify situations that put you at risk of exposure to Hepatitis B and other bloodborne pathogens:

Employee signature ____ Date __________

Committee Review date ____________________

Recommendations:

Signature of Business Services Manager ___________________________________ Date _________________