

Rush - Henrietta Central School District

Information Sheet

Confidential

Exposure to Possible Infectious Materials or Body Fluids

Your child,

has been involved in an incident, listed below, which may have exposed him/her to infected body fluid:

Certain serious blood borne infections, such as Hepatitis B and AIDS, may rarely develop as a result of this type of exposure. While the likelihood of infection in our school district is very minimal, we are obligated to inform you of this risk, and to advise you to take your child to his or her own doctor today to determine whether there was sufficient exposure to warrant testing and/or prophylactic inoculation.

Please understand that the school district cannot require an individual to undergo a blood test. Any decision for blood testing or treatment is PRIVATE between families and their personal physician.

Signature

Date

Rush-Henrietta Central School District

School Accident Report



Student Name _____

School Student Attends _____ Accident Date _____ Time _____

Grade _____ HR _____ Location of Accident _____

Address _____ Class _____

_____ Instructor in Charge _____

Birth Date _____ Phone _____ Position _____

Witness 1 _____

Parent/Guardian _____ Witness 2 _____

Nature of Injury _____

Describe Accident Fully

Nurse's Notes:

Treated By (check one) Doctor Hospital Dentist No Doctor Rx

If so, name of Doctor or Hospital _____ Date _____

Signature of Nurse

Date of Report

- Distribution:
- School Nurse Teacher
- Building Principal
- Business Office
- School Physician

- Insurance Form Sent To:
- Blue Cross _____ date
- Parent _____ date
- Other _____ date
- Name _____

SCHOOL ACCIDENT PROGRAM NOTICE OF PUPIL INJURY FORM

Mail completed form to:
 Attention: SAP Department
 Excellus BlueCross BlueShield
 PO Box 22999
 Rochester, NY 14692

EXCELLUS

A non-profit independent licensee of the BlueCross BlueShield Association

Section I – To be completed and signed by School. Forward copy to parent for completion.

Student Name: (Last, First, Middle Initial)	Student Birthdate: (mm/dd/yyyy)	Gender: Male Female
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School District Name:	School Identification Number/Program:
Name of School:	Was injury a result of a motor vehicle accident?: Yes No
Date if injury:	Place of accident: Inside school Coming to school Other On school grounds Returning to school
Type of injury:	Brief description of how injury occurred:

Witness or School Authority Signature: _____ **Date:** _____

Section II – To be completed and signed by Parent/Guardian. Forward copy to Excellus BlueCross BlueShield.

Is child covered under another health or dental insurance plan? Yes No		
If yes, please complete the information below.		
Is child covered under: Child Health Plus	Medicaid	Not Applicable
Name of Insurance Carrier:	Policy/Identification No:	
Is child covered under Father/Guardian Yes No Full Name: Address: (if different from pupil):	Medical Name of insurance carrier: Policy/Identification Number:	Dental Name of insurance carrier: Policy/Identification Number:
Is child covered under Mother/Guardian Yes No Full Name: Address: (if different from pupil):	Medical Name of insurance carrier: Policy/Identification Number:	Dental Name of insurance carrier: Policy/Identification Number:

- Please submit a copy to Excellus BlueCross BlueShield within 10 business days from the date of injury.
- In order to process claims under the School Accident Program (SAP), we must have this form completed and on file. For claims reimbursement, please submit a SAP claim form along with an itemized bill and Explanation of Benefits from the student's medical plan (if applicable).

Due to a New York State mandated regulation, all claims related to an accidental injury to a sound and natural tooth should be submitted to the student's medical plan first then to their dental insurance (if applicable). Submit any remaining balances to SAP with Explanation of Benefits from both the medical and dental plans.

Notice: An person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

Parent/Guardian Signature _____ **Date** _____

Copies: Excellus BlueCross/BlueShield • Parent (Guardian) • School (Records) • School (Nurse)

Rush-Henrietta Central School District

Exposure Incident Form

Name Student SS #
Address Phone
School Code
School Supervisor/Nurse

Description of Incident

Briefly describe what happened:

Complete the following section:

Wounds Did the incident involve a wound? Yes No Did the wound result in visible bleeding? Yes No
Was the wound caused by: needle human bite other sharp instruments
other

Was the object causing the wound covered with blood/body fluids? Yes No

Blood/Body Fluid exposure to mucous membranes

Did the individual blood/body fluids come in contact with your body? Yes No

What was the substance to which you were exposed?

I was not exposed blood feces urine emesis (vomit) sputum sexual fluids

If the substance was anything other than blood, was there any blood visible in the fluid? N/A Yes unknown

What part of your body was exposed to the substance? (check all that apply)

none mouth eyes nose skin (specify)

How long was your body part in contact with the substance?

If the exposure was to our skin, was your skin bruised in any way? Yes No

What was the nature of your skin abrasion? Acne Dermatitis Cracks due to dry skin

unhealed cuts/scratches no skin abrasion other (specify)

Which of the following procedures were being used at the time of the incident? (check all that apply)

cuts/open wounds covered with bandages goggles/glasses pocket ventilator/ambu bag

mask (vinyl/latex) gloves other (specify)

First line intervention after exposure: what did you do? washed hands/exposed area changed clothes

flushed eyes/rinsed mouth showered other (specify)

The supervisor/school nurse teacher was notified as follows: Date Time

Medical Intervention:

In the event of contact with blood and/or body fluid, it is suggested that you discuss with the school nurse / teacher:

- HBV antibody or previous vaccination status for HBV • The need for HBV/HIV antibody testing
• Notifying your physician or health care provider of the exposure to blood or body fluids immediately

Return this completed form to supervisor or school nurse/teacher.

In case of injury to the school nurse teacher or health professional: report incident to supervisor and complete form.

signature of student

date - time

signature of supervisor or school nurse/teacher

date - time