Temple University Department of Nursing

Post Exposure Responsibility Form

Student Name: ___________________________  Student ID: ___________________________
Date: ____________________

This form should be completed by the student within 24 hours after the exposure and submitted to the clinical coordinator within 48 hours after exposure.

ALL STUDENTS MUST be seen in the emergency department/employee health department or by their personal health care provider within 2 hours for blood and body fluids exposure or within 24 hours of TB an exposure. Failure to comply will result in dismissal from program. It is the student’s responsibility to obtain medical treatment and follow-up after exposure to blood or body fluids or tuberculosis. Treatment following exposure includes initial screening; counseling risk, health, and relationships; and follow up testing.

Initial all statements that are correct.

____ I have been seen in the emergency department/employee health department or by my personal health care provider within 2 hours after a bloody and body fluid exposure or within 24 hours of a TB exposure.

____ My exposure was to blood or body fluids and post exposure prophylaxis (PEP) measures were taken as appropriate (PEP measures may include blood work for baseline HIV, Hepatitis B and C; administration of immunizing agents; administration of antiretroviral treatment; and administration of immunoglobulin.)

____ My exposure was to TB, and I previously have had no history of a positive PPD test, a PPD test was placed and I was provided counseling related to signs and symptoms of TB.

____ My exposure was to TB, and I have a previously known positive PPD test, a PPD test was not placed but I was provided counseling related to signs and symptoms of TB and recommended follow up measures.

____ I plan to fully participate in all follow-up medical care as recommended by the emergency department/employee health department or my personal health care provider.

____ I have had a blood or body fluid exposure and I do not plan to participate in follow-up care as recommended.

____ I have had a TB exposure and I do not plan to participate in follow-up care as recommended. I understand my decision to no participate in continued monitoring for the presence of TB will require that I withdraw from the program.

The student must initial each statement below. The student’s initials indicate understanding of each statement.

____ I realize that I am responsible for any health care expenses related to this situation.

____ I realize that I have the right to refuse to be tested for exposure/infection.

_____________________________  _______________________________
Student signature      Date

_____________________________  _______________________________
Witness signature      Date

Witness printed name

THIS FORM MUST BE MAINTAINED FOR THE DURATION OF MY CLINICAL EDUCATION EXPERIENCE PLUS 30 YEARS.