

**Refusal of Post-Exposure Medical Evaluation**  
**For Bloodborne Pathogen Exposure**  
Transylvania County Schools — School Health & Safety

Print and complete this form only if the exposed individual refuses post-exposure medical evaluation by a healthcare professional. Send this completed form to TCS Health & Safety Director.

**Exposed Individual Information**

Name: \_\_\_\_\_

School: \_\_\_\_\_

Exposure Date: \_\_\_\_\_

**Exposure Information**

School where the incident occurred: \_\_\_\_\_

Type of protection equipment used (gloves, eye protection, etc.): \_\_\_\_\_

Describe how you were exposed: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Tell how this type of exposure can be prevented: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_**Statement of Understanding**

I have been fully trained in TCS's Exposure Control Plan, and I understand I may have contracted an infectious disease such as HIV, HAV, HCV or HBV. I also understand the implications of contracting these diseases.

It has been recommended by my employer that I receive follow up medical testing to determine whether or not I have contracted an infectious disease such as HIV, HAV, HCV or HBV. I have also been offered follow up medical care in the form of counseling and medical evaluation of any acute febrile illness (new illness accompanied by fever) that occurs within twelve weeks post exposure.

Despite all the information I have received, for personal reasons I freely decline this post-exposure evaluation and follow up care.

Exposed Individual's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Name: \_\_\_\_\_ Signature: \_\_\_\_\_