Frewsburg Fire District
Infectious Exposure Form

Exposed Member's Name: _____ Position: _____

Home Phone: _____ Incident #: _____

Name of Patient: _____ Sex: _____

Age: _____ Address: _____

Suspected or Confirmed Disease: _____

Transported to: _____

Transported by: _____

Date of Exposure: _____ Time of Exposure: _____

Type of Incident (auto accident, trauma): _____

Type of protective equipment utilized: _____

What where you exposed to:

Blood _____ Tears _____ Feces _____ Urine _____ Saliva _____

Vomitus _____ Sputum _____ Sweat _____ Other _____

What part(s) of your body became exposed? Be specific: _____

_____

_____

_____

_____

Did you have any open cuts, sores, or rashes that became exposed? Be specific: _____

_____

_____

How did exposure occur? Be specific: _____

_____

_____

Did you seek medical attention? _____Yes _____No

Where? _____ Date: _____

Contact Infection Control Supervisor: Date_____ Time: _____

Supervisor's Signature: _____ Date: _____

Member's Signature: _____ Date: _____

Infection Control Supervisor's Report

Medical facility notified? Yes _____ No _____

If Yes:

Name of Facility: _____ Date: _____

Address of Facility: _____

Name of Facility Contact: _____

Confirmed Exposure: _____

Member notified? Yes _____ No _____

Member's Signature: _____ Date: _____

Medical Follow-Up Action:

_____

_____

_____

_____

_____

Remarks:

_____

_____

_____

_____

_____

Infection Control Supervisor's Signature: _____ Date: _____