Snoqualmie Valley
Public Schools

8001 Silva Avenue SE*P.O. Box 400, Snoqualmie, WA 98065*Phone 425-831-8000*Fax425-831-8040

POST-EXPOSURE REPORT & EVALUATION

To be Completed by Physician

Medical reason for employee not receiving vaccine: [ ] Yes [ ] No

Explanation if yes: _____

Hepatitis B Vaccination Record:

#1 _____ (Mo Day Year)

#2 _____ (Mo Day Year)

#3 _____ (Mo Day Year)

#4 _____ (Mo Day Year)

#5 _____ (Mo Day Year)

Antibody Test Results:

_____

_____

_____

_____ _____

Physician's Signature Date

_____ _____

Physician's Name Typed/Printed Address

_____ _____

Phone Number Address

Employees Hepatitis B Vaccination History:

#1 _____ #2 _____ #3 _____
Mo Day Yr Mo Day Yr Mo Day Yr

Booster: _____ Titer Results: _____
Mo Day Yr

Following an exposure incident involving another individual, as described above, I have been counseled by my Supervisor to have a post-exposure medical evaluation as soon as possible and within twenty-four hours of the incident. I have been offered access to a health care provider who can offer this service.

[ ] Yes [ ] No

_____ _____
Employee's Name Date

_____ _____
Supervisor's Name Date

I have chosen to waive my right to the health care provider designated by the Snoqualmie Valley School District to provide a post-exposure medical evaluation.

[ ] Yes [ ] No

I accept responsibility for obtaining a post-exposure medical evaluation by a health care provider of my own choosing.

[ ] Yes [ ] No

_____ _____
Employee's Signature Date