



### **Puncture Incident in a School Setting**

I hereby give permission for my child \_\_\_\_\_  
to receive the following services from the Division of Public Health. Only those services that are  
authorized by means of a check mark in the box next to the service will be provided.

- Information pertaining to Hepatitis B and HIV (the virus that causes AIDS)
- Hepatitis B immunization
- Tetanus booster
- Hepatitis B Immune Globulin
- A blood test for previous hepatitis B exposure
- A baseline testing for anti-hepatitis C virus and a follow-up testing at 4-6 months for anti-HCV and/or testing for HCV RNA at 4-6 months
- A blood test for HIV exposure ... **OR**
- All procedures noted above as recommended by the DPH

\_\_\_\_\_  
Signature of parent or legal guardian

\_\_\_\_\_  
Date

**For Use by Division of Public Health Staff Only**

Weight \_\_\_\_\_ Amount of HBIG Administered \_\_\_\_\_ Site \_\_\_\_\_

Manufacturer \_\_\_\_\_ Lot # \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_