Westfield State University
Animal Care Program
Occupational Health & Wellness Survey

NOTE: This must be completed prior to working with animals and when any changes in medical conditions or animal exposure intensity occur. Below there is an option to decline participation in this survey. Please read thoroughly.

Name: (Last) _____ (First) _____

Campus/home Mail Address:_____

City: _____ State: _____ Zip Code:_____

Cell Phone #: (_____) _____ E-mail Address: _____

Department: _____

Birth Date: _____ Sex: ☐ M ☐ F

Ethnicity:☐ White/Caucasian ☐ Black ☐ Asian ☐ Indian ☐ Hispanic ☐Other_____

Personal Physician: Name: _____ Telephone number: _____

Area where handling animals:

☐ Animal Facility
☐ Field Only
☐ Classroom only
☐ Other _____ (please specify)

Status (check all that apply):

☐ Faculty/staff ☐ Undergraduate student ☐ Graduate student

☐ Other: _____ (please specify)

Please check all circumstances that apply. ("Contact" means direct handling or care)

☐ Contact with vertebrate animals. Specify: Common name: _____
☐ Contact with animal tissues/fluids not treated with chemical preservatives.
☐ No direct animal contact, but working in the same facility with animals or their non-preserved tissues.

Estimate animal contact time in **hours per week**: _____

Estimate non-animal contact time in **hours per week**: _____

Have you had a tetanus booster in the past 10 years?
☐ Yes (attach documentation if record is not in the medical record of the examining physician. Health Services has the tetanus record from admission files for current students)
☐ No (Current tetanus required).

Rabies Vaccine

NOTE: ***Rabies vaccination is recommended for individuals working with wild caught mammals only (e.g., Raccoons, Skunks, Bats, Ferrets, other flesh eating carnivores that do not receive rabies vaccination. Rabbits and rodents do not normally carry the rabies virus.):***

☐ **Does not apply.** I will not be working with wild caught mammals.

☐ **I have previously been vaccinated against Rabies:**

Date of Dose 1:_____ Date of Dose 2: _____

Date of Dose 3:_____ Date of most recent titer: _____

Name of administering physician or clinic: _____

☐ **I would like to be vaccinated against Rabies by the physician or clinic of my choice.** I understand that it is my responsibility to seek and obtain vaccination prior to beginning research with wild caught mammals and I responsible for any charges incurred for obtaining this vaccine. I also understand that failure to obtain vaccination will result in delay or decline of approval of any associated research protocols by the WSU IACUC.

☐ **I am declining to be vaccinated against Rabies.** I have reviewed the Center for Disease Control and Prevention's Vaccine Information Statement regarding the rabies vaccine, as indicated by my initials here: _____. This handout explains the risks and benefits of receiving the vaccine. I have been given the opportunity seek vaccination at the physician or clinic of my choice, but I am declining the vaccination at this time. I will immediately report any bite, scratch or similar contact with a wild mammal and seek appropriate medical treatment. I hereby agree to hold harmless Westfield State University and its employees, agents, members or officers from any liability for damages of any kind resulting from my failure to obtain a rabies vaccine at this time.

Signature: _____ **Date:** _____

Medical History

Do you have any current medical problems? ☐ Yes ☐ No
If yes, explain. _____

Do you have any chronic medical problems? ☐ Yes ☐ No
If yes, explain. _____

Have you had any of the following? (Check all that apply and **indicate when**)
☐ Pneumonia ☐ Restriction on lifting limit _____ Specify lbs
☐ Recurrent Bronchitis ☐ Arthritis ☐ Chronic Back or Joint Pain ☐ Heart Disease
☐ Carpal Tunnel Syndrome or Repetitive Motion Injury

Allergy History:

List all medications that you are presently on. (Especially all asthma/allergy medications including inhalers): ☐ none

_____

_____

_____ (press enter to add more lines)

List any allergies to medications: ☐ none

_____

_____

_____ (press enter to add more lines)

Do you have any of the following symptoms or conditions? (Check all that apply that **are not associated with a cold**.)

☐ Chronic cough
☐ Skin rash
☐ Runny nose, sinus congestion
☐ Shortness of breath/wheeze
☐ Asthma
☐ Chronic allergies (food, mold, dust)
☐ Itchy, irritated eyes
☐ Hay fever or other environmental seasonal allergies (pollen)

☐ None

Are you allergic to any of the following? (Check all that apply)

☐ Mice
☐ Weeds
☐ Food
☐ Dogs
☐ Rats
☐ Trees
☐ Pollen
☐ Cats
☐ Rabbits
☐ Grass
☐ Other: _____
☐ Raptors/Birds
☐ Latex

☐ None

☐ I would like to be seen by the medical staff.

Please be informed that certain medical conditions increase your risk of potential health problems when working with animals, these can include: animal-related allergies, chronic back injury, pregnancy and immunosuppression. If any of these conditions apply, inform your personal physician/health care professional of your work.

Other conditions: _____

Please check only one box below, sign, and date prior to submission to University Health Services or your personal physician.

☐ **I have answered the questions on this form truthfully and to the best of my knowledge and I agree to have the above information reviewed by the appropriate party listed on the next page. If I have taken this document to my personal physician, I understand that I am responsible for all associated costs, if any.**

☐ **I decline the completion of this form. I understand that my decision not to complete the survey will eliminate the benefit of professional medical surveillance review. If in the future, I continue to come in contact with animals because of my job and want to participate in the survey, I can complete the survey. WSU will offer me the option to complete or decline completion of the survey annually.**

_____ _____

Signature **Date**

IF YOU ARE A STUDENT, FACULTY or STAFF: Please schedule a meeting or make an appointment for a physical exam with your personal physician or clinic or your choice (you are responsible for any associated costs, if any). Bring the completed or partially completed form (clinician can assist in completing as needed prior to physical exam) at the time of your meeting or physical examination appointment.

This questionnaire may become part of your medical record at the clinic you visit. Only the next page (Clearance Recommendation Page), however, should be sent to the IACUC chair via IACUCChair@westfield.ma.edu.

Office Use Only:

Clearance Recommendation Page

Patient's Consent and Authorization

(Note to medical staff – This page only should be returned by the patient to the WSU Institutional Animal Care and Use Committee (IACUC). ... The remainder of this document should remain in the patient's medical record at the medical facility)

***Check only one box fill in information, add name, signature and date**

☐ I consent to and authorize (physician's name)_____ to release my approval status for work with animals and any applicable restrictions to the Westfield State University Institutional Animal Care and Use Committee and, if applicable, my supervising investigator. I understand this consent is revocable except to the extent action has already been taken. Authorization is not valid beyond one year from date of signature. Further disclosure or release of my health information is prohibited without specific written consent of person to whom it pertains.

☐ I _____ decline the completion of the Westfield State University occupational health and wellness survey. I understand that my decision not to complete the survey will eliminate the benefit of professional medical surveillance review. If in the future, I continue to come in contact with animals because of my job and want to participate in the survey, I can complete the survey. WSU will offer me the option to complete or decline completion of the survey annually

Print Patient name:	
Patient's signature	Date

Physician's Recommendations (Choose one from <u>each</u> table)

(Choose one from table 1)

	I am not aware of any contraindications toward participation in Animal Care or Handling.
	Physical examination required for determination. Please make an appointment.
	I believe the applicant can participate in animal care or Handling with the following restrictions
	I recommend the applicant **not** participate in Animal Care or Handling.

(Choose one from table 2)

	Re-evaluation required when any changes in medical conditions or animal exposure intensity occur
	Re-evaluation required annually

Practitioner's signature		Date:
Practitioner's name (print)	Phone:	Fax:
Clinic Address	City:	State & Zip

Once signed, the patient should scan **<u>this page only</u>** to pdf and send it to the IACUC chair via: IACUCChair@westfield.ma.edu.