Fitchburg State University

Animal Care Program

Occupational Health Survey

### NOTE: This must be completed prior to working with animals and when any changes in medical conditions or animal exposure intensity occur.

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  Classroom only

Field 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 invertebrate animals. Specify: Common name:

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 Fitchburg State University Health Services.** I understand that this vaccine will be provided free of any charge to me. *(Access to the pre-exposure vaccine for rabies virus has been restricted by the CDC due to a disruption in the global supply. Vaccination will be provided as vaccine is available through the CDC approval system.)*

**I would like to be vaccinated against Rabies by the physician or clinic of my choice.** I understand that I will be responsible for any charges incurred for obtaining this vaccine.

**I am declining** **to be vaccinated against Rabies.** I have received a copy of 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 to be vaccinated free of charge, 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 Fitchburg 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  Asthma

Skin rash  Chronic allergies (food, mold, dust)

Runny nose, sinus congestion  Itchy, irritated eyes

Shortness of breath/wheeze  Hay fever or other environmental seasonal allergies (pollen)

None

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

Mice  Rats  Rabbits  Raptors/Birds

Weeds  Trees  Grass  Latex

Food  Pollen  Other:

Dogs  Cats

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:**

**I agree to have the above information reviewed by the appropriate party listed on the Clearance Recommendation Page. If I have taken this document to my personal physician, I understand that I am responsible for all associated costs.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature Date**

**IF YOU ARE A STUDENT:** Please call Health Services to make an appointment for an exam (no cost) or take this form to your personal physician (you are responsible for any associated costs). Bring the completed or partially completed form (clinician will assist in completing as needed prior to physical exam) at the time of your physical examination appointment.

Health Services Office

Ground floor of Russell Towers

(978) 665-3643/3894

**IF YOU ARE FACULTY OR STAFF:** Bring or send the completed form to your personal physician (you are responsible for any associated costs).

**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 IACUC@fitchburgstate.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 FSU Institutional Animal Care and Use Committee (IACUC). ... The remainder of this document should remain in the patient’s medical record at the medical facility)***

I consent to and authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to release my approval status for work with animals and any applicable restrictions to the Fitchburg 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.

|  |  |
| --- | --- |
| Print Patient name: |  |
| Patient’s signature | Date |

### Practioner’s Recommendations (Choose one from each 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 restrictions detailed below. |
|  | 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 **this page only** to pdf and send it to the IACUC chair via IACUC@fitchburgstate.edu.