*Any health information disclosed, and this form, will be handled in compliance with HIPAA*

Principal Investigator: Enter name here

**Contact Identification**  Personnel type: [ ] Faculty [ ] Staff [ ] Student

Name: Last, First, Middle Initial Phone: ( ### ) ###-####. E-Mail: Enter ISU email.

1. ANIMAL CONTACT: [ ] Yes [ ] No – skip to 6. Allergy History

*I understand that due to my occupation and /or potential exposure to animals, I may be at risk of acquiring zoonotic diseases and/or animal-related allergies.* **Agreed** [ ]

1. Indicate types of animal contact you will have:

[ ]  Direct contact and handling of animals
[ ]  Direct contact and handling of non-fixed or non-sterilized animal tissues, animal fluids, or animal wastes

[ ]  Direct contact with non-sanitized animal caging or enclosures

[ ]  Service, repair or maintenance-related support to project animal equipment, devices and/or facilities

1. Select all of the species of animals you will be exposed to
*(the animal contacts listed in 2. above)*

a. [ ] Dogs b.[ ] Rabbits c.[ ] Rats or Mice d.[ ] Birds e.[ ] Guinea Pigs f. [ ] Wild Mammals

 g. [ ] Fish h. [ ] Reptiles/Amphibians i. [ ] Wild Non-Mammals j. [ ] Other Enter text here.

1. Do you have contact with animals outside of work?

[ ]  No [ ]  Yes, please list the species: Enter text here.

1. Indicate which symptoms you feel are caused by, made worse by, or are the result of your work
in an animal facility or with laboratory animals (click any that apply)

a. [ ] Watery, burning or itchy eyes b. [ ] Hives c. [ ] Rash d. [ ]  Cough e. [ ] Runny nose
g. [ ] Shortness of breath h. [ ] Chest tightness i. [ ] Wheezing j. [ ]  None of these

1. Allergy History – Indicate both the source and the allergenic conditions or responses you may have to the following (click any that apply and describe your reaction in the section at 6. b. below)

a. [ ]  None b. [ ]  Dog c. [ ] Cat d. [ ] Rabbits e. [ ] Rats or Mice f.[ ] Guinea Pigs g.[ ] Bird (feathers)
h. [ ] Farm Animals i. [ ] Sheep (wool) j. [ ] Swine k.[ ] Bird (feathers)
l. [ ]  Mold m. [ ]  Hayfever n. [ ]  Grasses o. [ ]  Wood p. [ ]  Trees q. [ ]  Latex
r. [ ]  Chemicals (list\*) Enter chemical names here. s. [ ]  Medications (list\*) Enter names here.
t. [ ] Other (list\*) Enter substance name here. *\*List for r., s., t., add extra page if necessary*

1. For allergens checked above describe your reaction, please:

Enter description of reaction(s) here, after the letter of the source as listed in *a. to t.* above.

1. Medical History and Conditions Contact Name: Last, First, Middle Initial

**a. Indicate any medical conditions you may have:**

[ ]  None [ ]  Allergic rhinitis [ ]  Asthma [ ]  Allergic conjunctivitis (itchy, watery eye form allergy)

[ ]  Skin rash [ ]  A natural parent or sibling with animal-related allergies

[ ]  Chronic coughing [ ]  Chronic allergies (food, pollens, dust, or chemicals

**b. History** – Self Immediate Details *(field will expand)*

*check box if true then describe* Family

Respiratory allergies, include Hay fever [ ]  [ ]  Enter details here.

Asthma [ ]  [ ]  Enter details here.

Skin Allergies [ ]  [ ]  Enter details here.

Food Allergies [ ]  [ ]  Enter details here.

Chronic Sinus Disease [ ]  [ ]  Enter details here.

Lung Disease [ ]  [ ]  Enter details here.

Heart Disease [ ]  [ ]  Enter details here.

Kidney Disease [ ]  [ ]  Enter details here.

Diabetes Mellitus [ ]  [ ]  Enter details here.

Cancer [ ]  [ ]  Enter details here.

Compromised Immune System [ ]  [ ]  Enter details here.

Any type auto-immune disorder [ ]  [ ]  Enter details here.

Hepatitis B | Hepatitis C [ ]  [ ]  Enter details here.

Sickle Cell Disease, G6PD Deficiency [ ]  [ ]  Enter details here.

**c.** **Immunizations – Provide year of last documented**

 TB/Tuberculin test: YYYY Tetanus/Diphtheria: YYYY
 Measles/Mumps/Rubella or MMR: YYYY
 Hepatitis A: YYYY Hepatitis B: YYYY Pertussis: YYYY Rabies: YYYY

**d. For All - Are you currently on any medications?** [ ]  No

 [ ]  Yes, list medication name with dosage: Enter medication and dosage here.

**e. Women** – Are you pregnant, attempting pregnancy or breast feeding: [ ]  Yes [ ]  No

**f. Please list any concerns or other health-related information the occupational health medical specialist performing this review should know.**

Enter concerns or other information here, field will expand. Attach an extra page if needed.

Contact Name: Last, First, Middle Initial

**Acknowledgements**

I understand that my signature(s) indicates that I have completed this form to the best of my knowledge.

**A. I acknowledge my responsibility**

to read and understand all occupational health documents provided to me by the principal investigator (PI) / primary researcher and/or the animal facility staff. It is my responsibility to ask questions if I do not understand anything stated in the documents or have questions about the subjects addressed in the documents. While the University compiles with all applicable health and safety laws and regulations and has implemented programs to protect and preserve my health and safety, I acknowledge that I am responsible to take reasonable action to ensure my own health and safety.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *A hardcopy signature is required*

**B. If personnel choose not to complete this medical surveillance form, the complete set of pages, with this signature page, are required to participate in the project protocol.**

**I chose not to complete this medical surveillance form**

I understand there are risks inherent in working with animals. I understand that by not completing this form there may be limits placed on the work I am allowed to perform in the animal facility or in my work in the field.

I understand that declining to complete this form does not exempt me from following all safety recommendations and policies associated with animal research-related activities.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *A hardcopy signature is required*

Print this form before submitting

Data will not be saved

To Submit:

Complete the form, sign and seal in envelope to address: Animal Facility STOP 8007

Hand Delivery option: Biological Sciences Office, Rm 227, Gale Life Sciences Bldg.

Contact Name: Last, First, Middle Initial

**Health Medical Specialist Review**

**Review Results**

**This applicant is approved to work within the following categories**

***(Reviewer, check all that apply)***

Category I

☐ Yes ☐ No Fish amphibians, reptiles or other animals with low risk of injury, zoonotic disease or allergies to animals.

Category II

☐ Yes ☐ No Rats, mice, rabbits, guinea pigs, birds and other animals with mild injury (primarily bites and scratches), zoonotic disease, but significant potential for allergies to animals.

Category III

☐ Yes ☐ No Dogs, wild rodents and other animals with moderate risk of injury (primarily bites, scratches), zoonotic disease (Rabies, tularemia, plague, Hantavirus, bacterial and fungal infections) and significant potential for allergies to animals.

☐ Yes ☐ No Snake Bite.

☐ Yes ☐ No Recommend physical examination.

☐ Yes ☐ No Unable to work with any categories of animals.

☐ Yes ☐ No Recommend follow-up interview and counseling.

 **Recommendations: (**For use by the Occupational Health Medical Specialist)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Specialist’s Name Signature Date