

Responses are strictly confidential

Name (Last, First)		Sex: M <input type="checkbox"/> F <input type="checkbox"/>		DOB:		Today's Date:	
Home or Campus Address:						Phone:	
Position: Staff <input type="checkbox"/> Student <input type="checkbox"/> P.I. <input type="checkbox"/> Volunteer <input type="checkbox"/>						Dept:	
Email:			Supervisor:			ACUP#:	
Please list below any known allergies. (ie; antibiotics, latex, etc.)							
Allergies: _____							
Please check boxes to animals that cause allergic symptoms. Check here if none: <input type="checkbox"/>							
Rats <input type="checkbox"/> Mice <input type="checkbox"/> Fish <input type="checkbox"/> Anoles <input type="checkbox"/> Frogs <input type="checkbox"/> Rabbits <input type="checkbox"/> Dogs <input type="checkbox"/> Cats <input type="checkbox"/> Zebra fish <input type="checkbox"/>							
Xenopus frogs <input type="checkbox"/> Chickens or Chicken eggs <input type="checkbox"/> Other (Please specify) _____							
Will you be working with any of these animals listed above? YES <input type="checkbox"/> NO <input type="checkbox"/>							
Check the boxes that reflect your symptoms when working around the animals listed above.							
Check here if no symptoms occur <input type="checkbox"/>							
Runny or stuffy nose <input type="checkbox"/> Itching <input type="checkbox"/> Rash <input type="checkbox"/> Hives <input type="checkbox"/>							
Sneezing <input type="checkbox"/> Hoarseness <input type="checkbox"/> Eyes watering <input type="checkbox"/> Coughing <input type="checkbox"/> Wheezing <input type="checkbox"/> Sore throat <input type="checkbox"/> Tightness in throat							
Bad breath <input type="checkbox"/> Eczema <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Tightness in Chest <input type="checkbox"/>							
Poor sense of smell <input type="checkbox"/> Frequent bronchitis <input type="checkbox"/>							
Questions 1-3: Check the box that signifies the amount of exposure you will have with the animal(s).							
1. No direct contact, but enter the animal room or animal is in workspace. <input type="checkbox"/>							
2. No direct contact with live animals but handle "unfixed" animal tissue and or fluids. <input type="checkbox"/>							
3. Direct contact with live animal(s); {e.g. handle, restrain, collection of specimens, administer drugs, etc.} <input type="checkbox"/>							
Note: Masks, gloves and lab coats are required while working with the animals in the colony							
Do you require any extra measures to reduce allergic symptoms? Yes <input type="checkbox"/> No <input type="checkbox"/>							
If so please list: _____							
Do you have your physician's clearance to work with animals if required? Yes <input type="checkbox"/> No <input type="checkbox"/> Pending <input type="checkbox"/> N/A <input type="checkbox"/>							
List any medication used to control symptoms including name, dosage and quantity.							
Medication		Dosage		Frequency			
Mark the appropriate boxes and list dates.							
Are you pregnant? YES <input type="checkbox"/> NO <input type="checkbox"/> N/A <input type="checkbox"/>							
Date of last Tetanus Booster: _____							
(If you are an attending college student, please contact the Bates Health Center for your current tetanus booster dates).							
Mark the boxes that you will be involved with regarding:							
Recombinant DNA <input type="checkbox"/> Infectious Agents <input type="checkbox"/> Human Blood, Body Fluids, Tissues, or Cells <input type="checkbox"/>							
If other, specify: _____							
Mark the Chemical or Physical agents you will be working with.							
Flammables <input type="checkbox"/> Caustic <input type="checkbox"/> Toxic <input type="checkbox"/> Reactive <input type="checkbox"/> Radiation/Radioisotopes <input type="checkbox"/>							
Anesthetic gases <input type="checkbox"/> Controlled drugs <input type="checkbox"/> Carcinogens <input type="checkbox"/> Heavy Metals <input type="checkbox"/>							
Other (List): _____							
Have you received safety training and are cleared to work with hazardous materials listed? Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>							
Health or Work Concerns: Is there any health or work concerns below you wish to discuss with the Occ. Health Nurse?							
YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, please list contact number you will prefer to be reached at: _____							

Wildlife/Field/Marine Studies
Check the boxes and/or list species you plan to come in contact with in your research:
Wild rodent <input type="checkbox"/> Raccoon <input type="checkbox"/> Fox <input type="checkbox"/> Squirrel <input type="checkbox"/> Bird <input type="checkbox"/> Fish <input type="checkbox"/> Others(list):
Have you ever had a Rabies Vaccine Series? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, list dates below: Series of 3: _____
Will you be in contact with rabies vector species? YES <input type="checkbox"/> NO <input type="checkbox"/>
Have you read and signed Bates liability waiver? YES <input type="checkbox"/> NO <input type="checkbox"/> N/A <input type="checkbox"/>
Have you read and signed the required forms/fact sheets regarding Hantavirus from the Maine Dept. of Health and also the Center for Disease Control? YES <input type="checkbox"/> NO <input type="checkbox"/> Have not received the paperwork <input type="checkbox"/> N/A <input type="checkbox"/>

I verify that the above information is accurate to the best of my knowledge.

Signature: _____ Date: _____