



ANIMAL RESEARCH MEDICAL FORM

In compliance with the Institutional Animal Care and Use Committee (IACUC) and Occupational Health and Safety Program (OHSP)

ANIMAL RESEARCH

Use this form if you are a research student, worker or personnel needing to obtain medical clearance for an animal research project. This form is to be re-submitted at any time there is a change in your health status and/or animal exposure(s).

DATE:	LAST NAME:	FIRST NAME:
DATE OF BIRTH:	AGE:	SEX: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
BATES ID#:	PHONE:	EMAIL:
ADDRESS:	CITY:	STATE: ZIPCODE:
POSITION: <input type="checkbox"/> STUDENT <input type="checkbox"/> FACULTY <input type="checkbox"/> STAFF <input type="checkbox"/> VOLUNTEER		
FACULTY OR WORK SUPERVISOR NAME:		EMAIL:
IS THIS FORM A RE-SUBMISSION DUE TO CHANGES IN YOUR HEALTH STATUS? <input type="checkbox"/> YES <input type="checkbox"/> NO		
CHECK THE BOXES BELOW IF THE STATEMENT IS APPLICABLE TO YOUR STATUS IN ANIMAL RESEARCH/ANIMAL CARE (CHECK ALL THAT APPLY)		
<input type="checkbox"/> DIRECT CONTACT WITH ANIMALS; (E.G. HANDLE, RESTRAIN, ADMINISTER DRUGS, ETC.)		
<input type="checkbox"/> NO DIRECT CONTACT BUT HANDLE "UNFIXED" TISSUE, CARCASSES, OR SPECIMENS		
<input type="checkbox"/> NO DIRECT CONTACT BUT ENTER THE ANIMAL ROOM OR ANIMAL WORKSPACE		
<input type="checkbox"/> WORKING WITH ANIMAL PATHOGENS/DISEASE AREAS (BIOSAFETY LEVEL 2)		
PLEASE CHECK OFF OR LIST THE ANIMALS YOU WILL BE WORKING WITH BELOW:		
<input type="checkbox"/> RATS <input type="checkbox"/> MICE <input type="checkbox"/> ZEBRAFISH <input type="checkbox"/> DOGS <input type="checkbox"/> CATS <input type="checkbox"/> RABBITS		
<input type="checkbox"/> ANOLES <input type="checkbox"/> QUAIL <input type="checkbox"/> WILD BIRDS <input type="checkbox"/> OTHER(PLEASE LIST):		
DO YOU HAVE ANY KNOWLEDGE YOU ARE ALLERGIC TO THE ANIMALS LISTED ABOVE? (IF YES, PLEASE SPECIFY) <input type="checkbox"/> YES <input type="checkbox"/> NO ANIMAL(S):		
WHAT WAS THE LEVEL OF ALLERGIC REACTION TO ANIMAL(S)?		
<input type="checkbox"/> RUNNY OR STUFFY NOSE <input type="checkbox"/> WATERING/ITCHY EYES <input type="checkbox"/> RASH <input type="checkbox"/> HIVES		
<input type="checkbox"/> TIGHTNESS IN THROAT <input type="checkbox"/> SHORTNESS OF BREATH <input type="checkbox"/> WHEEZING		
DO YOU RECEIVE ALLERGY SHOTS FROM YOUR PHYSICIAN (IF YES, LIST DOSE AND FREQUENCY)		
<input type="checkbox"/> YES <input type="checkbox"/> NO DOSAGE: FREQUENCY:		
DO YOU HAVE A PHYSICIAN'S CLEARANCE TO WORK WITH ANIMALS IF REQUIRED? <input type="checkbox"/> YES <input type="checkbox"/> NO		
DO YOU SUFFER FROM ANY NON ANIMAL ALLERGY? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES LIST):		
LIST SYMPTOM(S) THAT OCCUR WHAT YOU ARE REACTING TO THIS ALLERGY:		
HAVE YOU EVER BEEN TOLD BY A PHYSICIAN THAT YOU HAVE AN IMMUNE COMPROMISING MEDICAL CONDITION OR ARE YOU TAKING ANY MEDICATIONS THAT IMPAIR YOUR IMMUNE SYSTEM (STERIODS, IMMUNOSUPPRESSIVE DRUGS, OR CHEMOTHERAPY)? <input type="checkbox"/> YES <input type="checkbox"/> NO		
IF YES, EXPLAIN:		
WHEN WORKING WITH ANIMALS WHAT PERSONAL PROTECTIVE EQUIPMENT WILL YOU BE WEARING? (CHECK ALL THAT APPLY)? <input type="checkbox"/> GLOVES <input type="checkbox"/> MASKS <input type="checkbox"/> LAB COAT		
WILL YOU BE EXPOSED TO INFECTIOUS AGENTS/RECOMBINANT DNA? <input type="checkbox"/> YES <input type="checkbox"/> NO		



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WORKING WITH HAZARDOUS CHEMICALS REQUIRES SAFETY TRAINING
FLAMMABLES, CAUSTIC, TOXIC (HEAVY METALS) AND REACTIVES REQUIRE SAFETY TRAINING; WILL YOU BE EXPOSED TO ANY OF THIS CHEMICALS AND IF YES, PLEASE LIST: <input type="checkbox"/> YES <input type="checkbox"/> NO
CHEMICAL(S):
PLEASE CONTACT THE SAFETY COORDINATOR AT MHUGHES@BATES.EDU FOR TRAINING IF USING ANY HAZARDOUS OR TOXIC CHEMICALS:
ARE YOU PREGNANT? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
IS THERE ANY HEALTH CONCERN YOU WOULD LIKE TO DISCUSS WITH THE NURSE? <input type="checkbox"/> YES <input type="checkbox"/> NO

THIS SECTION ONLY IF WORKING WITH BEES/WASPS OR STINGING INSECTS

DO YOU KNOW OF ANY ALLERGIES TO BEES/WASPS OF STINGING INSECTS? <input type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, DO YOU HAVE A PHYSICIAN'S CLEARANCE TO WORK WITH INSECTS? <input type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, LIST DATE CLEARED _____

THIS SECTION FOR WILDLIFE RESEARCH ONLY

HAVE YOU EVER HAD OR DO YOU KNOW HAVE ANY OF THE FOLLOWING IMMUNIZATIONS OR DISEASES? <input type="checkbox"/> RABIES <input type="checkbox"/> TB
If Yes, list dates of shots required: 1 st : _____ 2 nd : _____ 3 rd : _____
What vertebrates will you be working with? <input type="checkbox"/> Birds <input type="checkbox"/> Wild Rodents _____ Other (please list) _____
Do you have a current tetanus shot? (within 10 years) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending

Signature _____

Date _____

Please return the completed form to Mary Hughes, Bonney Science Center, Room 185.