

Pepperdine University

Periodic Animal Contact Health Questionnaire

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 _____ Name of Employer: _____

Birth Date _____ Sex M F Date Hired : _____

Ethnicity: White/Caucasian Black Asian Indian Hispanic Other _____

Personal Physician: Name: _____

Physician Telephone number: _____

Status (check all that apply):

- | | |
|---|---|
| <input type="checkbox"/> Faculty/staff | <input type="checkbox"/> Undergrad/Grad. Hourly |
| <input type="checkbox"/> Visiting/temporary | <input type="checkbox"/> Undergrad/RA/Independent Study |
| <input type="checkbox"/> Unpaid graduate or undergrad | <input type="checkbox"/> Other: _____
(please specify) |

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

- Contact with vertebrate animals in the lab. Specify: Common name: _____
- Contact with vertebrate animals in the field. 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 in **hours per week**: _____

Estimate non direct animal contact time in **hours per month**: _____

Have you had a tetanus booster in the past 10 years?

- Yes: Date _____
(Health Services has the tetanus record from admission files for current students)
- No (Current tetanus required).

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

List any allergies to medications: none

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 problems with: 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 (continue as needed below): _____

I agree to have the above information reviewed by the appropriate personnel from the Pepperdine Student Health Center, the Institutional Animal Care and Use Committee and/or the Office of the Provost.

Signature

Date

Office Use Only:

Clearance Recommendation Page

Patient's Consent and Authorization

(Note to medical staff – This page only should be returned to Pepperdine’s IACUC Chairperson, Dr. Susan Helm, in the Natural Science Division at Pepperdine University. 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 Pepperdine University’s Institutional Animal Care and Use Committee (IACUC) and 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

Physician's Recommendations (Choose one from each table)

(Choose one from table 1)

<input type="checkbox"/>	I am not aware of any contraindications toward participation in animal care or handling.
<input type="checkbox"/>	I believe the applicant can participate in animal care or handling with the following restrictions:
<input type="checkbox"/>	I recommend the applicant not participate in animal care or handling.
<input type="checkbox"/>	There are medical concerns that require follow-up or referral to a specialist prior to clearance for participation in animal care or handling. Those concerns are:

(Choose one from table 2)

<input type="checkbox"/>	Re-evaluation required when any changes in medical conditions or animal exposure intensity occur
<input type="checkbox"/>	Re-evaluation required annually

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

Send this page only to Dr. Susan Helm, IACUC chairperson, in the Natural Science Division. Mail code #4321. Phone: (310) 506-4325. Fax: (310) 506-4785.

Please call the Health Center to make an appointment for an exam 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.

Pepperdine Health Center

Location: Student Assistance Center (SAC)

Hours: Monday - Friday, 8:00 a.m. - 5:00 p.m.

Phone: (310) 506-4316 (Option 3 for Operator)