**Nebraska Wesleyan University Institutional Animal Care and Use Committee**

**Occupational Health Risk Assessment Questionnaire**

**NOTICE:** Federal regulations and NWU Policy require all animal users to complete an Occupational Health Risk Assessment Questionnaire for a qualified medical physician to perform a risk assessment of research activities performed by NWU participants. Information provided in this questionnaire will become a part of your confidential medical records.

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| **Name:** |  | | |
| **Email Address:** |  | | |
| **Please Select:** | Faculty | Undergraduate |  |
| **If Student, Date of Birth:** |  | | |
| **Principal Investigator:** |  | | |

***\*\*\*Date of birth is requested for students to better assist the NWU Health Center in adding this form to your medical record.***

**What kind of animal contact will you have in your affiliation with NWU? (Check all that apply)**

No direct contact (visitor, Facilities Services, Campus Police, etc.)

Less than 8 hours a week of direct animal contact

More than 8 hours a week of direct animal contact

**What species of animals will you be exposed to in your affiliation with NWU?**

(This includes direct contact with animals, animal tissues and/or wastes, and animal enclosures.)

Mice  Birds  Amphibians  Other (list)

Rats  Fish  Reptiles  Other (list)

**Are you working with infectious agents in animals?**  Yes  No

**Laboratory Animals**: Inoculating animals with infectious agents. List agents:

**Medical History**

**Do you have any of the following? (Check all that apply)**

Allergies to animals (Please specify):

Asthma

Kidney or liver disease

Valvular heart disease

Chronic health problem such as diabetes

Condition treated with oral corticosteroids, radiation therapy or cancer therapy

History of problems with your spleen or absence of your spleen

Immune deficiencies

**Immunizations**

**Tetanus Booster:**  Within 10 years  Over 10 years  Unknown

**Notice:** If over 10 years or unknown, a Tetanus Booster is strongly recommended.

**Have you received the Rabies vaccination series?**  Yes  No

**If yes, please provide the date you completed the series:**

**Reason for being vaccinated:**  Post-Exposure  Pre-Exposure

**Other Medical Information**

Are you currently taking any medications?  Yes, list below  No  Decline to state

**Notice for Women:** For women who are pregnant or planning to become in pregnant, you should be aware that some animal-borne infections may pose a danger to the fetus. If you are pregnant or planning to become pregnant soon, please discuss your risk level with a healthcare professional at the Student Health Center or your personal health care provider prior to working with animals.

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| **Signature** |
| The above information is true and complete to the best of my knowledge and I am aware that deliberate misrepresentation may jeopardize my health. I understand that this information is confidential and will not be released without my knowledge and written permission.    Signature of Participant Date |

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| **Declining Participation in the Program**  If you have decided not to complete this questionnaire and not to participate in this aspect of the program, please date and sign this block. At any time that you decide to participate in the Occupational Health and Safety Program, you may do so. |
| **Occupational Health and Safety Questionnaire Waiver**  **I decline participation in the Occupational Health and Safety Questionnaire for animal users at this time.**  I have reviewed the Occupational Health and Safety Program  I understand the occupational risks of working with animals    Signature Date |

**You may use one of the following options to return your completed form:**

**•** **Mail via campus mail:** Karri Ahlschwede, R.N., B.S.N**.**, Director, Student Health Services

**•** **Email:** [kahlschw@nebrwesleyan.edu](mailto:kahlschw@nebrwesleyan.edu)

**Disclaimer: Email is not a secure form of transmission of Protected Health Information.**

* **Fax:** 402-464-7858

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| **For Occupational Health Use Only** |
| Primary Health Care Reviewer Signature Date  Comments: |