University of South Carolina Aiken
Occupational Health and Safety Program for Animal Handlers
Personnel Form

Completion of this form is required as part of the Occupational Health and Safety Program at USCA for persons listed on any Institutional Animal Care and Use Committee (IACUC) Protocol who have contact with animals used for research, teaching, or testing.

The Principal Investigator is responsible for insuring that each individual at risk under his/her oversight completes the attached forms, including the PIs themselves.

Personal Profile and Declination form:
Two-page form to be completed by all individuals listed on any IACUC protocol or those with significant animal contact. Page 2 is for declining any services as allowed by the program.

Return original to
Office of the Dean, College of Sciences and Engineering (803.641.3291)
University of South Carolina Aiken
attn: Occ Med Review and mark “Confidential”
University of South Carolina Aiken Occupational Health and Safety Program for Animal Handlers - Personal Profile

Completion of this form is required as part of the Occupational Health and Safety Program at USCA for persons who have contact with animals used for research, teaching, or testing.

Faculty_______ Staff_______ Student_______ Other (specify)_______

Date_________________ VIP #__________________ P.I. Name ________________________________

Name _____________________________________________________________________ Work Phone ________________________
(First) (Last) (Middle)

Dept. ____________________________ Unit ___________ Email______________________

Animal Contact Profile – check species worked with here at USCA

Rodents

Reptiles

Fish/amphibians

Wildlife (specify)

Other (specify, e.g., necropsy only, observation only)

ANIMAL ALLERGY CONCERNS (PLEASE CHECK ONE) –

________ I would like to discuss animal allergies with a medical professional.

________ I currently have no animal allergy concerns or concerns have been addressed.

RESPIRATOR USE (confer with your supervisor):

________ I will not require a respirator.

________ I will require the use of a respirator.

________ I will use a respirator for voluntary reasons. ________

I do not know at this time.

VACCINATIONS/TESTS - Please indicate below if and when you have had the following vaccinations.

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Mo/Yr</th>
<th>Don’t Know</th>
<th>Vaccination Requested</th>
<th>Serology Requested</th>
<th>Decline (complete pg 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tetanus Toxoid (needed every 10 yrs)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rabies immunization/serology (For work with potential rabies vectors, i.e. unvaccinated carnivores, skunks, raccoons, bats)</td>
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</tbody>
</table>

*Individuals with compromised immune systems and/or heart conditions should consult with a physician prior to working with animals.

I have answered the questions in this form truthfully and to the best of my knowledge.

I do not have any malady that would be deleterious to the laboratory animals.

_________________________________________________     _____________________________
(Employee's signature)               (Date)

Occupational Health & Safety Program for Animal Handlers
Last reviewed 9/2020
Declination Page

Directions: Use this page when the designated employee elects NOT to be vaccinated and/or declines medical surveillance/screening

I. Vaccination Declined

I decline obtaining the following vaccinations (initial box): ☐ Tetanus ☐ Other (specify)________________________________

I understand that due to my occupational exposure to animals used for research, teaching or testing, I may be at risk of acquiring disease. I have been instructed to be vaccinated. However, I declined to be vaccination at this time. I understand that by declining, I continue to be at risk of acquiring serious or fatal disease. If, in the future, I want to be vaccinated, I can update this form.

II. Occupational Health Program Medical Services Declined

I decline the medical surveillance/screening services (Form B) offered as part of the University of South Carolina Aiken Occupational Health and Safety Program for Animal Handlers. (initial box): ☐

I have been informed that due to the nature of my occupational exposure to animals, I may be at risk of acquiring a zoonotic, allergic or animal-related disease. The University of South Carolina Aiken has established a medical surveillance review program for early detection, diagnosis and treatment of animal-related illnesses. I understand that the records from the program are confidential. However, at this time, I choose to DECLINE the medical surveillance/screening services. I am aware that I continue to be at risk of acquiring an animal-related illness. If in the future I continue to have occupational exposure to animals while employed at the University and I elect to actively participate in the University's medical surveillance/screening program, I may do so. I therefore decline at this time to complete Form B.

__________________________________________________________      ______________________
(Employee's signature)                                                 (Date)

______________________________________________   Employee ID # or Net I.D. ___________________
(Printed name – First, Last)

Dept ________________________________________________ Unit _____________

P.I. Name__________________________________________
CONFIDENTIAL PERSONAL HEALTH HISTORY
Work and Medical History Form
University of South Carolina Aiken

Faculty______ Staff______ Student______ Other (specify)______

Name: _______________________________________________  Date:  _____________  Date of Birth:  _______________

Address: _____________________________________________________________________________________________

Net ID or Employee #: ______________ Telephone #:  _(______)________________  Sex         M          F

Job Title:  _______________ Department:  _______________ Unit ______  Starting Date/Years in Position _____________

Describe Duties: ______________________________________________________________________________________________

Will you be, or are you exposed to any known hazard (e.g., toxic chemicals, asbestos, heavy lifting, etc)? What type(s)? __________

______________________________________________________________________

Do you have any work related health concerns? ______________________________________________

WORK AND EXPOSURE HISTORY: Briefly describe previous jobs, titles, duties, and dates:

<table>
<thead>
<tr>
<th>Start Date</th>
<th>End Date</th>
<th>Employer</th>
<th>Job Title/Duties</th>
<th>Exposure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

Have you ever had a work related injury, changed jobs, assignments or lost work time because of an injury or other health problem(s); received Worker’s Compensation, or disability insurance? Please describe:________________________________________________________________

Have you ever been directly exposed (touching, breathing, etc.) to any of the following? Please check all the appropriate boxes. Indicate in the comment section below if this was at work, home, doing a hobby or a part time job.

- [ ] Acids
- [ ] Ammonia
- [ ] Anesthetic Agents
- [ ] Antineoplastic Drugs
- [ ] Other:

Comments: ________________________________________________________________________________________

Are there any other hazards which you are exposed to at home or doing hobbies or current part-time jobs? ____________

Please list: _______________________________________________________________________________________

Have you ever changed your residence or home because of health problems? Describe. ____________________________________

Do you live very near an industrial plant or hazardous waste site? Describe. ____________________________________
MEDICAL HISTORY
Check if you have any of the following and give the year

<table>
<thead>
<tr>
<th>Illness</th>
<th>Year</th>
<th>Illness</th>
<th>Year</th>
<th>Illness</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blackouts or Epilepsy</td>
<td></td>
<td>Ear Infection/ Ruptured Ear Drum</td>
<td></td>
<td>Liver Disease</td>
<td></td>
</tr>
<tr>
<td>Heart Trouble</td>
<td></td>
<td>Bone or Joint Problems</td>
<td></td>
<td>Cancer</td>
<td></td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td></td>
<td>Varicose Veins</td>
<td></td>
<td>Neurologic Disorder</td>
<td></td>
</tr>
<tr>
<td>Tuberculosis</td>
<td></td>
<td>Hernia</td>
<td></td>
<td>Carpal Tunnel</td>
<td></td>
</tr>
<tr>
<td>Diabetes, High Blood Sugar</td>
<td></td>
<td>Anemia/Other Blood Disorder</td>
<td></td>
<td>Neck/Shoulder Injury</td>
<td></td>
</tr>
<tr>
<td>Asthma, Bronchitis, Pneumonia, Other Lung Disease</td>
<td></td>
<td>High Cholesterol or Triglycerides</td>
<td></td>
<td>Tendonitis/Repetitive Strain Injury</td>
<td></td>
</tr>
<tr>
<td>Spleen Absent</td>
<td></td>
<td>Vision Problems</td>
<td></td>
<td>Knee/Foot Problems</td>
<td></td>
</tr>
<tr>
<td>Dermatitis or Other Skin Disease/Rash</td>
<td></td>
<td>Urinary or Kidney Problems</td>
<td></td>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

Describe above positives: ____________________________________________________________________________________
________________________________________________________________________________________________________

Have you ever had back pain or injury which disrupted your usual activities? □ yes □ no If yes, please describe all episodes which resulted in absence from work or school (include dates): ____________________________________________
_______________________________________________________________________________

Any other illness? Please describe and give dates: ________________________________________________________________
______________________________________________________________________

Please list current medications: _____________________________________________________________
_______________________________________________________________________________

Do you have any concerns related to your current work or previous jobs and your reproductive history? (i.e., infertility, miscarriages, still births, or birth defects)__________________________________________________________________
_______________________________________________________________________________

Have you ever been in the hospital? □ Yes □ No.
Please list any hospitalizations and/or surgeries for major medical illnesses, injury, or procedures: _______________________
____________________________________________________________________________________________________________

Allergy History:
Allergy to medications: ________________________________________________________________
To Animals: _________________________________________________________________
To Other Agents? Specify: _______________________________________________________________
To Protective Gloves or Latex Allergy (glove dermatitis) ______________________________________________

I certify to the best of my knowledge that the above information is true.

I understand that this evaluation (history review) is related to my job and does not replace routine health care and physical examinations, by my own doctor.

The object of this form is to gather relevant information about occupational history, untoward effects of chemicals and other exposures from the workplace, allergy history, current medications and current health problems. It serves as a baseline for when an employee seeks medical evaluation at the University of South Carolina Aiken Student Health Services. This is not a pre-employment, it is a pre-placement questionnaire, and it will not have any power in terms of deterring employment. Furthermore, newly hired employees are free to omit information one may feel is not relevant to the scope of one’s job or to the care one may receive from the medical care provider.

_______________________________________________________________________________

Signature
Date