

**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"

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# 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) (Middle) (Last)

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.

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

**\*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)

## University of South Carolina Aiken Occupational Health and Safety Program for Animal Handlers - Personal Profile

### 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:

Start Date	End Date	Employer	Job Title/Duties	Exposure

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.

- |   |   |  |   |  |
|---|---|--|---|--|
| <input type="checkbox"/> Acids                | <input type="checkbox"/> Asbestos             | <input type="checkbox"/> Formaldehyde (Formalin) | <input type="checkbox"/> Mercury          | <input type="checkbox"/> Phenol        |
| <input type="checkbox"/> Ammonia              | <input type="checkbox"/> Carbon Tetrachloride | <input type="checkbox"/> Gluteraldehyde          | <input type="checkbox"/> Noise (loud)     | <input type="checkbox"/> Radiation     |
| <input type="checkbox"/> Anesthetic Agents    | <input type="checkbox"/> Carcinogens          | <input type="checkbox"/> Ketones                 | <input type="checkbox"/> Organic Solvents | <input type="checkbox"/> Radionuclides |
| <input type="checkbox"/> Antineoplastic Drugs | <input type="checkbox"/> Ethylene Oxide       | <input type="checkbox"/> Lead                    | <input type="checkbox"/> Pesticides       | <input type="checkbox"/> X-rays        |
| <input type="checkbox"/> 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. \_\_\_\_\_

—

# FORM B

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## MEDICAL HISTORY

Check if you have any of the following and give the year

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

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