**James Madison University Institutional Animal Care and Use Committee**

**Occupational Health Risk Assessment Questionnaire**

**NOTICE:** Federal regulations and JMU Policy require all animal users to complete an Occupational Health a Risk Assessment Questionnaire in order for a qualified medical physician to perform a risk assessment of research activities performed by JMU 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 | [ ] Graduate |
| **If Student, Date of Birth:**  |       |
| **Principal Investigator:** |       |

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

**What kind of animal contact will you have in your affiliation with JMU? (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 JMU?**

(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:** Medical Director, University Health Center, MSC 7901

**• Email:** healthctr@jmu.edu

**Disclaimer: Email is not a secure form of transmission of Protected Health Information. If submitting electronically, upload ONLY a PDF or a Word document. Image file format, e.g., JPEG or PNG, cannot be scanned into the medical record.**

* **Fax to the Attention of Medical Director, University Health Center: (**540) 568-6176

**\*\*Do NOT send to the Office of Research Integrity\*\***

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