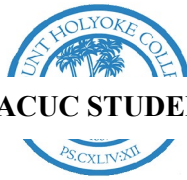


Obtaining Your Animal Lab Health Clearance

Instructions for MHC Students

1. Complete the attached Questionnaire, sign it and bring it to the Health Center. If Health Center staff have any questions, or need additional information about your medical history, they will reach out to you.
2. If at any time during the school year there is a change in your health please report it to Health Services immediately and ask them if your Lab Clearance should be re-evaluated.
3. If you have any questions regarding this process please contact Cheryl McGraw in the Psychology & Education Office at cmcgraw@mholyoke.edu.



MOUNT HOLYOKE COLLEGE IACUC STUDENT HEALTH CLEARANCE FORM

Name:	Date:
Major:	Date of Birth:
Email:	Phone:

ROLE	<input type="checkbox"/> Class Name: _____ with Professor: _____
	<input type="checkbox"/> Lab Research working in which faculty member's Lab: _____
	<input type="checkbox"/> Animal Care Assistant supervised by: _____

ANIMAL/TISSUE EXPOSURE	
<input type="checkbox"/> Rodents (mice, rats)	<input type="checkbox"/> Frogs
<input type="checkbox"/> Reptiles	<input type="checkbox"/> Fish
<input type="checkbox"/> Other: _____	

FREQUENCY OF CONTACT	
<input type="checkbox"/> Daily	
<input type="checkbox"/> 1-3 times per week	
<input type="checkbox"/> 1-3 times per month	
<input type="checkbox"/> Infrequent (0-6 times per year)	

FACILITIES	
Will you need access to an animal housing facility?	<input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, which location(s)?	
<input type="checkbox"/> Carr	<input type="checkbox"/> BSL-2 access required
<input type="checkbox"/> Reese	
<input type="checkbox"/> Clapp	

HEALTH HISTORY	
Do you currently have, or have you ever, had any of the following:	
<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	Asthma, COPD, or other chronic respiratory conditions/diseases
<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	Environmental allergies (e.g. pollen, mold, dust)
<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	Skin allergies (e.g. reaction to latex)
<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	Allergies after exposure to animals or their cages/bedding, including sneezing, running/stuffy nose, watery/itchy eyes, coughing, wheezing, shortness of breath, or skin rash/hives.
<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	Tick-borne diseases
<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	Salmonella, MRSA, or fish-handlers' infections

HEALTH HISTORY (continued)			
<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown	Diabetes
<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown	Anaphylaxis
<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown	Splenectomy
<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown	Rheumatoid Arthritis
<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown	Connective Tissue Disease (i.e. Lupus)
<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown	Immune Deficiency
<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown	Cancer/Malignancy
<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown	Chemotherapy
If you responded yes to any of the preceding, please explain:			

MEDICATIONS & IMMUNIZATIONS
Do you currently take any biologic or immunosuppressant medications? <input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, please list: _____
Please list all other medications: _____
Please indicate which immunizations you have received and submit a copy of your immunization records.
<input type="checkbox"/> Tdap <input type="checkbox"/> Tetanus (in the past 10 years) Date of last tetanus booster: __/__/____
<input type="checkbox"/> Hepatitis B <input type="checkbox"/> Rabies
<input type="checkbox"/> Other (please specify): _____

Do you wear a respirator for any reason?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Would you like to be fitted for a respirator before working with animals? (requires enrollment in respirator fitting program)	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Do you have any concerns regarding your health, relating to the handling of laboratory animals?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Please specify: _____		

I authorize the Mount Holyoke College Health Services and AEIOU Occupational Health or my healthcare provider (“provider”) to release to the Mount Holyoke College Institutional Animal Care and Use Committee and to the Mount Holyoke College Department of Human Resources any information in my medical record that pertains to my proposed work with animals and any restrictions that may relate to that work. This information is being released solely for the purpose of informing those offices of my eligibility to work with animals during my employment there. I understand that I have the right to revoke this authorization in writing to Health Services or to my provider, as appropriate. I understand that while the Mount Holyoke College Institutions Animal Care and Use Committee and the Department of Human Resources will make every effort to keep my information private, it is possible that some of this information may be subject to re-disclosure without my authorization.

Signature: _____ Date: _____

For Office Use Only		
Reviewed by:	Date:	Recommendations: