Science Center
Institutional Animal Care and Use Committee
50 College Street, South Hadley, MA 01075-1462
tel 413-538-2844 fax 413-538-2456

Instructions for Completing the Animal Lab Health Clearance Form

Mount Holyoke College Faculty and Staff may submit their completed Animal Lab Health Clearance Form to their own health care provider or may schedule an appointment with Work Connection at Holyoke Medical Center. When scheduling an appointment with Work Connection, tell them you are an employee of Mount Holyoke College and the appointment is for an OLAW Animal Lab Health Clearance Questionnaire. Work Connection will bill MHC. There will be no personal cost for your appointment. NIH recommends that all animal care personnel be immunized against tetanus. CDC recommends that adults receive the tetanus vaccine every 10 years. If your tetanus vaccination is not current, you will have the opportunity to receive the tetanus vaccine at no charge to you during your clearance exam at the Work Connection. If you are not up to date, but decline to receive the tetanus vaccine at this time, you will still be able to receive it free of charge at a later date if you continue to have exposure to animals in the lab.

1. Work Connection
   Holyoke Medical Center
   575 Beech St.
   Holyoke, MA 01040
   413-534-2546
   https://www.holyokehealth.com/services-specialities/the-work-connection/non-injury-care/

2. Pages 1 and 2 of the Health Clearance Form should be retained by the health care provider. Do not send this portion of the form to Mount Holyoke College.

3. A signed copy of page 3 of the Health Clearance Form should be sent to Cheryl McGraw either by email or postal mail. (Health care providers should retain a copy of page 3 of this form for their records.)

   Cheryl McGraw
   Mount Holyoke College
   Department of Psychology & Education
   50 College Street
   South Hadley, MA 01075
   cmcgraw@mtholyoke.edu

4. If at any time in the future you undergo a significant change to your health, an updated Animal Lab Health Clearance Form is required.

If you have any questions please contact Cheryl McGraw.
cmcgraw@mtholyoke.edu
413.538.2844

MOUNT HOLYOKE ANIMAL LAB HEALTH QUESTIONNAIRE

Name	Date
Department/Major	Supervisor
Email	Phone
Are you enrolled in an IACUC protocol? ☐ No ☐ Yes	If yes, what protocol number?

ROLE		
	☐ Principal Investigator	☐ Post-graduate/Fellow
	☐ Animal Care Technician	☐ Departmental/Lab Staff
	☐ Student	☐ Other:

ANIMAL/TISSUE EXPOSURE

☐ Rodents (mice, rats)	☐ Frogs
☐ Reptiles	☐ Fish
☐ Other	

FREQUENCY OF CONTACT

☐ Daily
☐ 1-3 times per week
☐ 1-3 times per month
☐ Infrequent (0-6 times per year)

FACILITIES

Will you need access to an animal housing facility? ☐ No ☐ Yes
If yes, which location(s)?

☐ Carr ☐ BSL-2 access required
☐ Reese
☐ Clapp

HEALTH HISTORY

Do you currently have, or have you ever, had any of the following:

☐ No ☐ Yes ☐ Unknown	Asthma, COPD, or other chronic respiratory conditions/diseases
☐ No ☐ Yes ☐ Unknown	Environmental allergies (e.g. pollen, mold, dust)
☐ No ☐ Yes ☐ Unknown	Skin allergies (e.g. reaction to latex)
☐ No ☐ Yes ☐ 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.

If you responded yes to the previous question, how often and to which animals?

HEALTH HISTORY (continued)			
☐ No	☐ Yes	☐ Unknown	Tick-borne diseases
☐ No	☐ Yes	☐ Unknown	Salmonella, MRSA, or fish-handlers' infections
☐ No	☐ Yes	☐ Unknown	Diabetes
☐ No	☐ Yes	☐ Unknown	Anaphylaxis If yes, source:
☐ No	☐ Yes	☐ Unknown	Splenectomy
☐ No	☐ Yes	☐ Unknown	Rheumatoid Arthritis
☐ No	☐ Yes	☐ Unknown	Connective Tissue Disease (i.e. Lupus)
☐ No	☐ Yes	☐ Unknown	Immune Deficiency
☐ No	☐ Yes	☐ Unknown	Cancer/Malignancy
☐ No	☐ Yes	☐ Unknown	Chemotherapy

MEDICATIONS & IMMUNIZATIONS

Do you currently take any biologic or immunosuppressant medications? ☐ No ☐ 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.***

☐ Tdap ☐ Tetanus (within the past 10 years) Date of last booster:

☐ Hepatitis B ☐ Rabies

☐ Other (please specify):

Do you wear a respirator at work?	☐ No	☐ Yes
Would you like to be fitted for a respirator before working with animals? (requires enrollment in respirator fitting program)	☐ No	☐ Yes
Do you have any concerns regarding your health, relating to the handling of laboratory animals?	☐ No	☐ Yes

Please specify: _____

Signature: _____ Date: _____

1. Pages 1 and 2 of this form to be retained by Health Care Provider. Do not send to Mount Holyoke College.

2. Email completed page 3 to Cheryl McGraw (cmcgraw@mtholyoke.edu) or send via postal mail to Cheryl McGraw, Mount Holyoke College, Psychology & Education, 50 College Street, South Hadley, MA 01075.

3. Health Care Provider should retain a copy of Page 3 for their records.

4. Please contact Cheryl McGraw with any questions about this form or process: cmcgraw@mtholyoke.edu or 413.538.2844.

MOUNT HOLYOKE

Institutional Animal Care and Use Committee

Animal Lab Health Clearance Affidavit

- One copy of this form should be kept with the health care provider
- one copy emailed to Cheryl McGraw, MHC IACUC Chair (cmcgraw@mtholyoke.edu)

PART I – To Be Completed by MHC Faculty or Staff Member

I authorize 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 Environmental Health and Safety 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 Environmental Health and Safety 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.

Name: _____ Email: _____

Signature: _____ Date: _____

PART II – To Be Completed by Doctor

I, _____, have examined _____ or am already familiar with their medical history, have reviewed _____'s Animal Lab Health Clearance form, discussed with them the work they do with animals, and have determined that:

☐ no restrictions or accommodations are needed for them to engage in this work, or

☐ the following restrictions or accommodations should be in place for them to engage in their work with animals.

_____

Name: _____ Date: _____

Business Address: _____

Phone: _____ Email: _____

Signature: _____