

Occupational Health and Safety Program

Laboratory Animal Resources

Binghamton University
State University of New York
P.O. Box 6000 Health Services, IN-204
(607) 777-4610, Fax: (607) 777-2881

Health Screening Questionnaire for Faculty, and Students who are visiting Binghamton University and intend to participate in any activities during their visit which may involve any potential exposure to research animals, (field and/or laboratory environments)
****Confidential Medical Information**** - This information is strictly for the use of the Occupational Health and Safety Program for Laboratory Animal Resources and may not be released to anyone without your written consent

Section 1: Personal Information – Please Print

Contact Information

Last Name _____ First _____ Middle _____
Home Address _____ City _____ State _____ Zip _____
Campus Phone/Local Phone _____ Cell# _____
Email _____ Birth Date _____ Sex: M F

In Case of an Emergency

Person to be notified _____ Relationship _____ Phone _____
Name of Primary Care Physician _____ Phone _____

University Department Information – (During your visit at Binghamton University)

Department _____ Supervisor’s Name _____ Supervisor’s Phone _____

Date of arrival and anticipated duration of visit _____

Section 2: Risk Assessment

Visitor Status

- Undergraduate Student Animal Technician Visiting Faculty
 Graduate Student Visiting Veterinary Staff
 Other (list job description) _____

Please check all the animal species which you intend to work with while visiting:

- Rat/Mouse Reptile Other (describe) _____
 Bird Rabbit

Please check the box which approximates the time you plan to spend in an animal lab or doing field work:

- Daily Weekly Monthly Rarely (Less than once a month)
 No handling of animals planned while visiting but will be working in the Animal Lab environment

Section 3: Medical History Screening (Please check if you have a history of Asthma or Allergies)

1. **Asthma** **If Yes, are your symptoms under control with your present treatment?** Yes No
Are your Asthma symptoms triggered by any of the following? (Check all that apply)
 Allergies Fumes Cold Heat Other (please describe) _____
2. **Allergies** **If there is a history of Allergies please check what you are allergic to:** Dust Food(list) _____
 Latex Mold Pollens(list) _____ Medications (list) _____ Animals(list) _____
3. **Have you been told by a health practitioner that your Immune system is suppressed or compromised?** Yes No
4. **Are you presently being treated for any acute or chronic illness?** Yes No
5. **(For females only) Are you pregnant?** Yes No
6. **Please list the dates of these most recent vaccinations or boosters)** Tetanus _____ Hepatitis B _____
7. **Do you presently have any work restrictions?** Yes No **If Yes, please explain:** _____

I attest that the information above is correct to the best of my knowledge.

Signature _____

Date _____

Date Reviewed _____