**UNIVERSITY OF OKLAHOMA**

**ANIMAL HANDLER’S HEALTH QUESTIONNAIRE**

This questionnaire shall assess health risks relating to your involvement in the Animal Care and Use Program for the University of Oklahoma, Norman Campus (OU-Norman). All faculty, staff, students, volunteers, and visitors who may work with or around animals as part of their involvement at OU-Norman ***should complete and submit this Questionnaire at least once every 3 years***.

**INSTRUCTIONS**

Complete each section of this Questionnaire as accurately and completely as possible. Missing or incorrect responses may slow processing and ultimately delay clearance to work with animals. Once *all* sections of this Questionnaire are complete, submit a copy to the Charles B. Goddard Health Center by **ONE** of the following methods:

1. Email a copy to [ghc-medrecs@ou.edu](mailto:ghc-medrecs@ou.edu)
2. Fax a copy to **(405) 325-7542**
3. Mail a copy to **Animal Health Questionnaires, Charles B. Goddard Health Center, 620 Elm Avenue Norman, OK 73019**

Once this Questionnaire has been submitted, an occupational health specialist may contact you directly with questions. You may also request an in-person consultation, if desired. If the occupational health specialist finds all responses in this questionnaire to be satisfactory, they will notify the OU-Norman IACUC Office that you are cleared to participate in the Animal Care and Use Program.

**SECTION A**

*Staff, students, and other personnel should first consult with their faculty mentor or supervisor to ensure all departmental and billing information entered here is accurate. Missing or incorrect responses may delay processing.*

1. Today’s Date (mm/dd/year):

Click or tap to enter a date.

2. Full Name of Animal Handler:

|  |
| --- |
|  |

3. Date of Birth (mm/dd/year):

Click or tap to enter a date.

4. Employee ID or OU ID Number:

*You may leave this section blank* ***only if*** *you are not an employee of OU and do not have an OU ID number.*

|  |
| --- |
|  |

5. Animal Handler Contact Information:

Mailing Address:

|  |
| --- |
|  |

Telephone Number:

|  |
| --- |
|  |

Email Address:

|  |
| --- |
|  |

6. Name of Principal Investigator/Supervisor (if different from Animal Handler listed above):

|  |
| --- |
|  |

7. Principal Investigator/Supervisor Campus Telephone Number:

|  |
| --- |
|  |

8. University Department:

|  |
| --- |
|  |

9. Contact for Billing:

*Enter the name of a department administrator who can direct payment for this health screening.*

|  |
| --- |
|  |

10. Billing Contact Information:

Billing Address:

|  |
| --- |
|  |

Telephone Number:

|  |
| --- |
|  |

Email Address:

|  |
| --- |
|  |

**SECTION B**

1. Employee Status (check all that apply):

Faculty/Staff

Student

Research Technician/Associate

Post-doctoral Researcher

Veterinarian

Laboratory Animal Technician

Classroom Instructor

Visiting Researcher

Other – Specify:

|  |
| --- |
|  |

2. Species of Animal Use (*check all that apply*) and Estimated Hours per Week:

|  |  |  |
| --- | --- | --- |
|  | **Species** | **Estimated Hours Per Week** |
|  | Bats |  |
|  | Birds |  |
|  | Chinchillas |  |
|  | Fish |  |
|  | Frogs |  |
|  | Guinea Pigs |  |
|  | Mice |  |
|  | Rabbits |  |
|  | Rats |  |
|  | Reptiles |  |
|  | Wildlife |  |
|  | Other Species – Specify:   |  | | --- | |  | |  |

3. Have you received a tetanus booster immunization within the past 10 years?

*Select one.*

Yes – Enter the approximate date in which you last received a tetanus booster (mm/dd/year):

Click or tap to enter a date.

No, but I am interested in receiving a tetanus booster in accordance with CDC recommendations.

*You will be contacted by* Goddard Health Center *staff to schedule this immunization.*

No, and I am not interested in receiving a tetanus booster at this time.

*Due to my occupation, I may be at risk of acquiring infection from the tetanus bacteria. I have been given the opportunity to be vaccinated, at no charge to me; however, I decline the tetanus vaccination at this time. I understand that by declining this vaccine I continue to be at risk of acquiring tetanus, a serious condition. If, in the future I want to be vaccinated with the tetanus vaccine, I can receive the vaccination at no charge to me.*

4. Will you be working with animals known to be infected or that will intentionally be administered an infectious agent(s) or hazardous chemical(s)?

*Select one. If you are not sure, please consult with your supervisor to verify.*

No

Yes – Please identify the infectious agents and/or hazardous chemicals you will be working with:

|  |
| --- |
|  |

5. Will you be working with volatile gases (e.g., nitrous oxide, isoflurane)?

*Select one. If you are not sure, please consult with your supervisor to verify.*

No

Yes – Please identify the volatile gases you will be working with:

|  |
| --- |
|  |

6. Will you be working with human body fluids, tissues, or cell lines?

*Select one. If you are not sure, please consult with your supervisor to verify.*

No

Yes

1. If yes, please list the human body fluids, tissues, or cell lines you will be working with:

|  |
| --- |
|  |

1. If yes, have you been immunized against Hepatitis B?

*Select one*.

Yes – Enter the approximate date in which you last received a Hepatitis B immunization (mm/dd/year):

Click or tap to enter a date.

No, but I am interested in receiving an immunization against Hepatitis B in accordance with CDC recommendations. *You will be contacted by* Goddard Health Center *staff to schedule this immunization.*

No, and I am not interested in receiving a hepatitis B immunization at this time.

*I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be immunized with HBV vaccine, at no charge to me; however, I decline HBV vaccination at this time. I understand that by declining this vaccine I continue to be at risk of acquiring HBV, a serious disease. If, in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with HBV vaccine, I can receive the vaccination series at no charge to me.*

7. As part of your animal handling duties, will you be required to wear an N95 respirator?

*Select one. If you are not sure, please consult with your supervisor to verify.*

No

Yes – Please contact the OU Environmental Health and Safety Office ([EHSO@ou.edu](mailto:EHSO@ou.edu)) to request an N95 fit test.

8. Will you be working with bats in the wild?

*Select one. If you are not sure, please consult with your supervisor to verify.*

No

Yes

1. If yes, please enter the approximate date in which you last received rabies pre-exposure prophylaxis (mm/dd/year):

Click or tap to enter a date.

*Based on the CDC’s* Rabies Pre-exposure Prophylaxis Guide*, pre-exposure recommendations are based on an individual’s exposure risk. You will be contacted by* Goddard Health Center *staff to discuss your exposure risk, receive the primary vaccination series for rabies virus, or receive serologic testing to assess your need for booster vaccinations.*

**SECTION C**

1. Are you allergic or possibly allergic to the animals you currently work with?

No

Yes

1. If yes, please list the animals that cause your allergy symptoms:

|  |
| --- |
|  |

1. If yes, have you been seen by a physician for this condition?

Yes  No

2. Do you have any past history of breathing or respiratory problems, such as asthma, COPD, etc.?

Yes  No

3. Do you currently smoke or have you smoked in the past?

Yes  No

4. Are you currently around other smokers?

Yes  No

5. Do you have any history of allergic or bad reactions to medications?

No

Yes – Please explain:

|  |
| --- |
|  |

6. Have you ever had a severe (anaphylactic) reaction?

*Symptoms typically include: lightheadedness, fainting, lump in the throat, difficulty breathing, rapid heart rate, hives of the skin, nausea, vomiting, etc.*

No

Yes – Please describe what may have caused the reaction:

|  |
| --- |
|  |

7. Have you ever been tested for allergies?

No

Yes – Please list what kinds of allergies you have tested positive for:

|  |
| --- |
|  |

8. Do you have any problems with your immune system?

No

Yes – Please explain:

|  |
| --- |
|  |

9. Are you allergic or do you think you might possibly be allergic to any animals you have at home or the animals that you currently work with?

No

Yes – Please enter the following information:

1. List the animals that you believe may be causing your symptoms:

|  |
| --- |
|  |

1. What kind of symptoms have you noticed?

|  |
| --- |
|  |

1. Have you been evaluated by a physician for these symptoms?

Yes  No

**SECTION D**

Please list in the box below any condition(s) that you feel would aid in the assessment of this form. Certain medical conditions increase your risk of potential health problems when working with animals. These can include animal-related allergies, chronic back injury, pregnancy, and immunosuppression. If any of these conditions apply, inform your personal physician/health care professional of the nature of your work.

|  |
| --- |
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**UNIVERSITY OF OKLAHOMA**

**ANIMAL HANDLER’S HEALTH QUESTIONNAIRE**

**FOR COMPLETION BY HEALTH PROFESSIONAL ONLY**

Please use the information in this form to evaluate whether the applicant should be approved to work with the animal species listed above in Section B, Question 2. If additional information is required, or if an in-person consultation is necessary to make your determination, please contact the Animal Handler directly using the contact information in Section A.

Once the evaluation is complete, please complete the following information and email a copy of this summary page to both the Animal Handler and the IACUC Office ([IACUC@ou.edu](mailto:IACUC@ou.edu)).

Today’s Date (mm/dd/year):

Click or tap to enter a date.

Name of Animal Handler:

|  |
| --- |
|  |

Animal Handler’s Email Address:

|  |
| --- |
|  |

Evaluation Notes

|  |
| --- |
|  |

This individual \* **is / is not** \* medically cleared to work with the animal species listed in Section B.2.

Reviewer’s Initials or Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**BILLING:**

Billing should be directed to the department with which the applicant is affiliated. Please see Section A, Questions 9–10 for contact information that pertains to billing.