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| C O N F I D E N T I A L | | | | |
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| **The University of Mississippi** | | | | |
| Occupational Health Evaluation | | | | |
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| **Instructions:**   1. **Complete Part I and II of this form. If you decline to provide the information in Part II, you may not be approved to work with animals.** 2. **Contact University Health Services for an appointment to be seen by a healthcare provider. \*Non-UM students/staff/faculty will need to see their personal physician\***   **Students: Call 662-915-7274**  **Employees: Call 662-915-6550**   1. **Be sure to take a printout of both this completed form AND your completed Risk Inventory to your appointment.** 2. **After the healthcare provider signs Part III, return ONLY that page to the IACUC office (mailbox on first floor of Barr Hall or scan to iacuc@olemiss.edu).** | | | | |
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| **PART I** ***(to be completed by the employee with assistance from the Director/Supervisor/Principal Investigator if needed)*** | | | | |
| **Name** | **Last:** Last Name | **First:** First Name | | **MI:** MI |
|  |  |  | |  |
| **Today’s Date** Today’s Date | | **UM Personnel #** UM ID# | | |
|  | |  | | |
| **Gender  Female  Male** | | **Date of Birth** | | |
|  | |  | | |
| **Date of last tetanus vaccination:**       **UNKNOWN** | | | | |
|  | | |  | |
| **Campus Address** | | | **Phone** | |
|  | | |  | |
| **Home Address** | | | **Phone** | |
|  | | |  | |
| **Department/Unit** | | | **Phone** | |
|  | | |  | |
| **Position Title** | | |  | |
|  | | |  | |
| **Supervisor** | | | **Phone** | |
|  | | |  | |
| **Personal Physician’s Name** | | | **Phone** | |
|  | | |  | |
| **Physician’s Address** | | | | |
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| **PURPOSE: Certain drugs and medical conditions may place you at increased health risk in certain work environ­ments that involve animal research. Such drugs and conditions include but are not limited to steroids, allergies, cancer, chronic diseases, pregnancy, surgical procedures, and absence of spleen, stress, and deficiencies of the immune system. This information is requested to benefit you and the Occupational Health physician, who reviews this form to recognize the health risks posed to you by animal research and to recommend ways to reduce those risks. You do not have to provide this information, however, if you decline you may not be approved to work with animals.** | | | | |
|  | | | | |
| SELECT ONE: | | | | |
| I agree to provide this information. | | | | |
|  | | | | |
| I have read and understand the above section entitled ‘Purpose’ and I understand  the confidentiality safeguards, but I decline to provide the information requested. | | | | |
| Signature: Date: | | | | |

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| **PART II** ***(to be completed by the employee with assistance from the Director/Supervisor/Principal Investigator if needed)*** | | | | | |
| **Check the appropriate response for each item below.** | | | | | |
| **1. Allergies** | | | | | |
| **Drugs (list):** | **Describe Reaction (hives, rash, difficulty breathing, anaphylaxis, etc)** | | **additional information:** | | |
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| **Environmental:** |  | | | | |
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| **2. Current conditions** | | | | | |
| **Condition:** | | **Acute or Chronic:** | | | **additional information:** |
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| **3. Previous Surgeries** | | | | | |
| **Procedure:** | | **Date:** | | | **additional information:** |
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| **4. Medications (including allergy shots)** | | | | | |
| **Medication:** | **Amount:** | | | **Dosage:** | |
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|  |  | | |  | |
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| **5. Do you have problems with your immune system:** | | | | | |
| **Yes – describe:** | | | | | |
| **No** | | | | | |
| **6. Are you pregnant? Y N NA** | | | | | |
| **7. Are you planning to conceive within the next 12 months?** **Y N NA** | | | | | |

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| **C O N F I D E N T I A L** | | | | | |
| **The University of Mississippi** | | | | | |
| **Occupational Health Evaluation** | | | | | |
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| **Part III** | | | | | |
| **Enrollment Confirmation** | | | | | |
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| **Instructions to Participant:** Return **ONLY** Part III of this form to the IACUC Office (100 Barr Hall – inbox on first floor marked IACUC or [iacuc@olemiss.edu](mailto:iacuc@olemiss.edu)). If any information is missing or the form is not signed by a healthcare provider, it will not be processed. | | | | | |
| **Instructions to Provider:** Please check the applicable boxes then sign and date below. **Return only Part III of this form to the participant.** If any vaccinations are needed, please administer them. If fit testing is recommended, please refer the patient for scheduling. Please limit written comments to those for the IACUC office (no PHI). | | | | | |
| **Participant Information:** | | | | | |
| **Name** | **Last:** Last Name | **First:** First Name | **MI:** MI |
|  |  |  |  |
| **Today’s Date** Today’s Date | | **UM Personnel #** UM ID# | |
|  | |  | |
| **Provider Review:** | | | |
| **I have reviewed the risk inventory and self-reported health history for the above-named individual.**  **Based on my review and examination, I have made any necessary recommendations (i.e. vaccinations, personal protective equipment, allergy management, fit testing) to the above named individual.**  **My signature below indicates the above-named individual (  has) (  has not) fulfilled the requirements for enrollment in the Animal Care Program’s Occupational Health and Safety Program.**  **Comments:** | | | |
| **Signature Date** | | | |
| **Print Name** | | | |