UNIVERSITY OF HOUSTON-CLEAR LAKE
OCCUPATIONAL HEALTH AND SAFETY PROGRAM (OHSP)
FALL 2011

Introduction: Participation in the UHCL Animal Care and Use Occupational Health and Safety Program (OHSP) is required by all employees and students who will be conducting research or taking courses that include animal use at UHCL. This program has been approved by UHCL’s Institutional Animal Care and Use Committee and by Susan Leitner Prihoda RN, MS, FNP, Director of UHCL Health and Disability Services. Personnel and students with a history of allergies are strongly encouraged to fill out the medical health questionnaire and discuss their medical history with Susan Leitner Prihoda. Arrangements can be made by calling the UHCL Health Center at 281-283-2626 or going to SSCB 1.301.

Instructions:

Form #1: UHCL Animal Care Occupational Health Enrollment Form

Please print last and first names on top portion of form.

1. Employees: All employees must fill out and submit Form #1 annually with an updated Health Surveillance Questionnaire [Forms #2 and #3].
2. Students: All new and continuing students must fill out Form #1 on an annual basis.
3. Visitors / Contractors / Others are subject to the same rules set forth in UHCL’s OHSP and must complete appropriate forms and obtain prior approval from authorized animal care designee or medical health professional before entering UHCL facility.
   - Option One – If submitting Health Surveillance Questionnaire (HSQ) [Forms #2 and #3] to UHCL Health Center for review, (a) initial how submitting the completed HSQ [Forms #2], and (b) initial statement, “I understand my risks as presented in the training.”
   - Option Two – If taking HSQ [Form # 2] to personal physician, initial both statements.
   - Option Three – If choosing to decline enrollment in UHCL OHSP, initial both statements. Must complete and submit Animal Care Medical Declination Form [Form #4] and skip Forms #2 and #3.

Sign and date Enrollment Form #1:
Completed Forms #1 are retained by the Office of Sponsored Programs (OSP): (a) Employees return to OSP, Box 44, B2531; and (b) Students return to the Instructor.

Form #2: UHCL Health Surveillance Questionnaire (HSQ) for Laboratory Animal Contact

Form #3: Medical Questionnaire Approval or Denial Form (Page 7)

1. Form #2 (pages 2-6): Individual completes medical history.
2. Form #3 (page 7), Print first and last names. Circle appropriate UHCL position status.
Submit completed Forms #2 and #3 according to designated choice in Option One of Form #1.

Form #4: Animal Care Medical Declination Form

Form #4: Print names, sign, and date if individual declines having medical questionnaire reviewed by a Health Professional before participating in UHCL’s Animal Care Program or entering the facility at UHCL.
Completed forms are retained by the Office of Sponsored Programs (OSP): (a) Employees return to OSP, Box 44, B2531; and (b) Students return to the Instructor.
OHSP
FORM 1

UHCL Animal Care Occupational Health Enrollment Form
Employees must fill this form out annually with an updated Medical Surveillance form.
UHCL Animal Care Occupational Health Enrollment Form
Employees must fill this form out annually with an updated Medical Surveillance form.

Last name: ___________________________  First name: ___________________________

Option One:
____ I am submitting the Health Surveillance Questionnaire (HSQ) in a sealed envelope after the training to the program designee for delivery to the UHCL Health Center.
____ I am submitting the Health Surveillance Questionnaire (HSQ) to the UHCL Health Center by mail or in person.
____ I understand my risks as presented in the training.

Option Two:
____ I am taking the Health Surveillance Questionnaire to my personal physician for review and approval to participate in the Animal Care Program. I will then bring my doctor’s written approval/ and/or recommendations to the UHCL Health Center for final review.
____ I understand my risks as presented in the training.

Option Three:
____ I choose to sign the Medical Declination form.
____ I understand my risks as presented in the training.

Approved by UHCL ACO Program Designee
University of Houston-Clear Lake

Health Surveillance Questionnaire for Laboratory Animal Contact

UHCL Health and Disabilities Service Center
2700 Bay Area Blvd, Box_260
Houston, TX 77058-1098
281-283-2629

Confidential Medical Information

PURPOSE: The purpose of this form is to obtain individual health history from employees and students who are in the Animal Care Program. Visitors are subject to the same rules set forth in the Occupational Health and Safety Program. This form will be used to evaluate appropriate medical needs in regards to handling laboratory animals.

CONFIDENTIALITY STATEMENT: This form requires that you provide personal health information. This information is protected by State and Federal law, as well as University policy. The confidentiality of your personal health information will be strictly maintained by the University of Houston – Clear Lake (UHCL) Health and Disabilities Service Center. All information you provide will be used and/or disclosed to the minimal extent necessary to evaluate your safety when working with animals. Should you not complete this form after your introductory training course, you may send it by regular mail or interoffice mail to the address above.

It is up to you to communicate your health status to a health professional or your superiors.

A UHCL Health Professional will review the responses from this medical questionnaire before granting individuals medical clearance to work with animals within the Animal Care Program or to enter the facility. The UHCL Health professional reserves the right to refer individuals to their personal physician before granting them clearance into the Animal Care Program. In these cases, the individuals must provide documentation from their personal care physician to the Health Center for final review. If working with animals poses an unreasonable health risk to the individual, the University reserves the right to refuse individuals from participating in this program.

If cleared into the program, the UHCL Health Center professional will notify the Animal Care Program director of your acceptance as well as any physical limitations you may have upon entering the program or the facility. If rejected, then a rejection form will be provided to the Animal Care program director. You may also choose to obtain the approval of your personal physician before entering this program.
INSTRUCTIONS: Please complete entire form. Answers left blank will be assumed to be a negative response. The information you supply will be submitted to the UHCL Health Center for review. For questions about this form, please contact: Susan Leitner Prihoda RN, MS, FNP, Director of UHCL Health and Disability Services, at UHCL Health Center, telephone 281-283-2629.

Personal Information

Last Name:________________________________   First Name: _______________________

Birth date:________________________  Email address:_____________________________

Visitor/Student/Faculty/Staff: _____________________________________________________

Have you previously filled out an animal handler questionnaire, medical surveillance, or had vaccinations at UHCL’s Health Center or the UH’s Health Center?

No___    Yes___

Vaccines:

Please indicate what vaccines you have been inoculated with. The Animal Care Occupational Health and Safety program requires that all employees and students have had their tetanus vaccination. Please indicate below when you last received this vaccination as well as others. If possible, please provide a copy of your vaccines.

Note* Should you require a booster for Tetanus, you can obtain this vaccine as part of your regular health check-up from your personal care physician, or you can receive the vaccine at the University of Houston-Clear Lake’s Health Center.

<table>
<thead>
<tr>
<th>Vaccines</th>
<th>Date</th>
<th>Vaccines</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B #1</td>
<td></td>
<td>Tetanus</td>
<td></td>
</tr>
<tr>
<td>Hepatitis B #2</td>
<td></td>
<td>Q Fever</td>
<td></td>
</tr>
<tr>
<td>Hepatitis B #3</td>
<td></td>
<td>Varicella</td>
<td></td>
</tr>
<tr>
<td>Other?</td>
<td></td>
<td>Other?</td>
<td></td>
</tr>
</tbody>
</table>
**Tuberculosis Testing**

Have you had a PPD (TB) Skin test?  Yes□ No□

Date of last PPD skin test. ____________  Result: □ Positive □ Negative

If POSITIVE, date of last chest X-ray _________

If POSITIVE in the past, please indicate Yes/No for each of the following:

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fever</td>
<td>□</td>
<td>□</td>
<td>Chronic Cough</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Bloody Sputum</td>
<td>□</td>
<td>□</td>
<td>Shortness of Breath</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Weight Loss</td>
<td>□</td>
<td>□</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Animal / Biological Agent Contact**

Please indicate all animals you may work with below, and whether they are laboratory bred or wild:

<table>
<thead>
<tr>
<th>Fish</th>
<th>Rats</th>
</tr>
</thead>
<tbody>
<tr>
<td>Turtles</td>
<td>Mice</td>
</tr>
<tr>
<td>Snakes</td>
<td>Other:</td>
</tr>
<tr>
<td>Bats</td>
<td>Rats</td>
</tr>
</tbody>
</table>

**Please indicate tissue, blood, or biological agents that you work with below:**

Do you work with human blood/tissue/or any known human diseases?  Yes □ No □

If yes, please explain.

Do you work with animal tissue/blood/or any known animal or zoonotic disease?  Yes □ No □

If yes, please explain.

Do you work with any other pathogenic materials or biological agents?  Yes □ No □

If yes, please describe:
Do you also work at another facility where nonhuman primates or nonhuman primate tissues are housed? Yes □ No □
Do you or will you be working with primate tissues? Yes □ No □
Do you or will you be working in an area where primates or primate tissues are housed or handled? Yes □ No □
Do you or will you be working with recombinant DNA technology? Yes □ No □

If yes, does the research involve techniques in which viable, recombinant DNA-containing micro-organisms are used to infect animals that would then require Bio-safety level 3 containment? Yes □ No □

Medical History

Have you had a prior history of the following conditions? Yes □ No □
If yes, please indicate the condition(s), and enter the date of onset (if known).

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>Date</th>
<th>Condition</th>
<th>Yes</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pneumonia</td>
<td></td>
<td></td>
<td>Recurrent Bronchitis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tuberculosis</td>
<td></td>
<td></td>
<td>Heart Disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rheumatic Fever</td>
<td></td>
<td></td>
<td>Heart Murmur or Valve Disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
<td>Kidney Disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Liver Disease</td>
<td></td>
<td></td>
<td>Cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disorders</td>
<td></td>
<td></td>
<td>Loss of Consciousness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seizures</td>
<td></td>
<td></td>
<td>Arthritis</td>
<td></td>
<td></td>
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<tr>
<td>Chronic Back or Joint</td>
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<td></td>
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<tr>
<td>Pain</td>
<td></td>
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</table>

Have you been told by a physician that you have an immune compromising medical condition or are you taking medications that impair your immune system (steroids, immunosuppressive drugs, or chemotherapy)? Yes □ No □

Are you currently taking any medications (Including non-prescription)? Yes □ No □
If yes, list here: ________________________________________________________________

For Women: Are you pregnant, or planning to be pregnant in the next year? Yes □ No □
Are you allergic to latex gloves? Yes □ No □ Don’t know □
Animal Related Injuries or Illnesses

Have you ever contracted a disease from animals, or experienced an animal related injury (including bites, scratches, needle sticks, etc.)? If yes, please indicate the last 5 occurrences.

<table>
<thead>
<tr>
<th>Date</th>
<th>Injury/Illness</th>
<th>Treatment Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td>Injury/Illness</td>
<td>Treatment Location</td>
</tr>
<tr>
<td>Date</td>
<td>Injury/Illness</td>
<td>Treatment Location</td>
</tr>
<tr>
<td>Date</td>
<td>Injury/Illness</td>
<td>Treatment Location</td>
</tr>
</tbody>
</table>

Animal Allergies

Has your health status changed in the last year? □ No □ Yes, please explain: ____________

Have you had any recent problems with the following symptoms? Yes □ No □

Please indicate which symptoms you have experienced (check the yes or no box next to each symptom).

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Watery or itching eyes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Runny nose</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sneezing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wheezing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic cough</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shortness of breath</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chest tightness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rash or hives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic allergies (dust, pollen, food, mold)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic Asthma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Periodic Asthma Attacks</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Emergencies?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Are these more frequent while at work? Yes □ No □

Have you been seen by your own physician for any allergies? Yes □ No □

Have these required any treatment with over-the-counter or prescribed medications (Claritin, Singular, Benadryl, decongestants, eye drops, etc)? Yes □ No □

Have you had to wear a respirator, goggles or protective clothing to protect yourself from allergies (e.g., hay fever [rhinitis], eye symptoms, hives or asthma) at work? Yes □ No □

Have you had an allergy test performed? Yes □ No □
Do any of these produce allergic symptoms?

<table>
<thead>
<tr>
<th></th>
<th>Dogs</th>
<th>Cats</th>
<th>Cattle</th>
<th>Horses</th>
<th>Bird (Feathers)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pigs</td>
<td>Nonhuman Primates</td>
<td>Rabbits</td>
<td>Goats</td>
<td></td>
<td>Sheep (Wool)</td>
</tr>
<tr>
<td>Rats or Mice</td>
<td>Guinea Pigs</td>
<td>Alfalfa</td>
<td>Weeds</td>
<td></td>
<td>Trees</td>
</tr>
<tr>
<td>Chemicals</td>
<td>Latex</td>
<td>Wood</td>
<td>Grasses</td>
<td></td>
<td>Mold</td>
</tr>
<tr>
<td>Other</td>
<td>List:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If you suspect you may have work related allergies or have any other questions about your health status or this form, please contact:

**Susan Leitner Prihoda RN. MS. FNP.**  
Director of UHCL Health and Disability Services  
SSCB S1301  
UHCL-Health Center  
Houston, TX 77058-0300  
Phone: 281-283-2629  
Email: Prihoda@uhcl.edu

**ADDITIONAL INFORMATION:** For detailed information on the hazards associated with the Animal Care Program, the following personnel may be contacted.

UH Division of Animal Care Operations  
Christina Aguilar, IACUC Coordinator  
713-743-9199  
ckgoka@uh.edu

UHCL Risk Management Office  
Niki Pearce  
281-283-2104  
pearcen@uhcl.edu

UHCL Animal Research Facility Director  
Chris Ward, Ph.D.  
281-283-3303  
wardechris@uhcl.edu
Medical Questionnaire Approval or Denial Form

Name:

Circle one: Staff Student Faculty Visitor
Circle appropriate status below:

A. Approved
This individual has provided adequate responses to the questionnaire and is medically approved to participate in the Animal Care Program. Refer the individual back to the Health Center for reevaluation if the individual begins to show symptoms of allergies or any other negative health concerns or injuries.

B. Status Waiting: Contingent on Physician’s approval
This individual has provided negative responses to the questionnaire and therefore cannot begin to participate in the Animal Care Program. This individual must receive approval from their own personal care physician and submit documentation (such as their professional opinion) to the Health Center before consideration into the program.

C. Reviewed by Personnel Physician.
This individual has provided to the University of Houston-Clear Lake’s Health Center the professional opinion of their own physician to partake in the Animal Care Program.

1. Approved.
This individual is cleared of any initial negative health concerns and can participate in the program.

2. Contingent on Safety Protocol, Doctor Requirements and/or Recommendations
If the individual is to participate in the program, they must be provided engineering controls, additional respiratory protection, etc. as to protect themselves from allergens or any other ailment.

3. Declined
Due to the severity of animal allergens and/or other health disorder, it is unsafe for this individual to participate in the program.

Reviewed by the Office of UHCL Health and Disability Services:

<table>
<thead>
<tr>
<th>Name &amp; Title printed</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
</table>

Submit to Office of Sponsored Programs
Attention: Dr. Paul E. Meyers
UHCL Campus Box 44
Phone: 281-283-3015
OHSP
Form 4

Animal Care
Medical Declination Form
Animal Care
Medical Declination Form

I am aware of the general risks of having direct and indirect exposure to animals within the University of Houston-Clear Lake’s Animal Care Facility. Even though it is for my own protection, I am choosing to decline having my medical questionnaire reviewed by a UHCL Health Professional before participating in the Animal Care Program or to enter the facility. In addition, I am also declining the option of having my personal physician to review my current health status and to provide medical clearance for me to work with animals or enter the animal care facility. I am aware that the tetanus vaccine is a requirement to work in this facility. By declining to provide information about my medical history, I am also declining to release knowledge about my vaccine status. Due to this action, I have revoked all liabilities should I become ill or suffer death as a result of my not fulfilling the initial vaccine requirements of this program or filling out the medical questionnaire in its entirety. I further agree to indemnify and hold harmless the Institution and its governing board, officers, employees, and any other representatives not mentioned from liability.

Print Name:  

Signature:  

Date:  