# College of Charleston
# Confidential Medical Information
# Student Animal Worker Health Screening Questionnaire

*Students: Please call Student Health Services to arrange an appointment with a health care provider at 953-5520. Please complete pages 1 – 3 of this form and bring the entire form with you at the time of your appointment.* ***This form contains confidential medical information for Health Services only – do not give this form to the Principal Investigator.***

Name: ______________________________________________Birth date: ____________

College ID # _______________________________Local Phone# _____________________

Department: ______________________________________________________________

Previous Evaluation at College of Charleston Student Health Service? ☐ Yes ☐ No

Today's Date _____________

**Status:** (***check all that apply)***

□ Graduate Student □ Undergraduate Student

□ Other _____________________________

## Role History:

Indicate the type/s of animals you will be handling (Check all that apply):

☐ Dogs ☐ Cats ☐ Guinea Pigs ☐ Amphibians/Reptiles

☐ Rabbits ☐ Fish ☐ Birds ☐ Lab Mice/Rats

☐ Voles & Chipmunks ☐ Other _____________

Did you receive instruction regarding species-specific risks and handling information from their principal investigator? ☐ Yes ☐ No

Do you work with non-human primates, with primate tissues, or in an area where primates or primate tissues are housed or handled? ☐ Yes ☐ No

Do you work with feral (wild) animals or random source (class B) dogs or cats? ☐ Yes ☐ No

Do you work with human blood products or human tissue? ☐ Yes ☐ No

***continued***

Name________________________College ID #__________________Date______________

## Medical History

What are your ongoing medical problems? Use an additional sheet of paper if necessary.

Have you had (check all that apply)?:

| | | |
|---|---|---|
| ☐ Pneumonia | ☐ Recurrent Bronchitis | ☐ Tuberculosis |
| ☐ Heart Disease | ☐ Rheumatic Fever | ☐ Heart murmur & Valve Disease |
| ☐ Diabetes | ☐ Kidney Disease | ☐ Liver Disease |
| ☐ Cancer | ☐ Gastrointestinal Disorder | ☐ Loss of Consciousness |
| ☐ Seizures | ☐ Arthritis | ☐ Chronic Back or Joint Pain |
| ☐ Cystic Fibrosis | ☐ Emphysema or Chronic Lung Condition | |

Have you ever contracted a disease from animals, or experienced an animal related injury (including bites, scratches, needlesticks, etc)? ☐ Yes ☐ No If yes, please explain below:

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 If yes, explain below:

Are you currently taking any medications? ☐ Yes ☐ No If yes, list below:

For Women: Are you pregnant, or planning to be pregnant in the next two years? ☐ Yes ☐ No

*continued*

Name_________________________College ID #___________________Date______________

## Allergy History

List any allergies to medications: _______________________________________________

Do you have any of the following (Check all that apply)?:

☐ Chronic cough ☐ Asthma ☐ Itchy, irritated eyes

☐ Hay fever ☐ Skin rash ☐ Chronic allergies (food, pollens, dust)

Are you allergic to (Check all that apply)?

☐ Dog ☐ Cat ☐ Cattle ☐ Horse ☐ Bird (feathers)

☐ Hog ☐ Primates ☐ Rabbit ☐ Goat ☐ Sheep (wool)

☐ Rat or mice ☐ Guinea Pig ☐ Alfalfa ☐ Weeds ☐ Trees

☐ Chemicals ☐ Latex ☐ Wood ☐ Grasses ☐ Animals at your work site

☐ Insect stings/bites ☐ Other (list):

## Immunizations:

Indicate date of most recent vaccination (or blood test to document immunity). Mark "X" if you do not recall the date. Mark "?" or leave blank if you are unsure.

____ Measles ____ Mumps ____ Rubella ____ Hepatitis A

____ Hepatitis B ____ Rabies ____ CMV ____ Toxoplasmosis

____ "Q" Fever ____ Yellow Fever ____ Smallpox vaccine

____ Tuberculosis vaccine (BCG)

Date of last tetanus booster:____________________

Date of last PPD (tuberculin) skin test:_________________________ ☐ Positive ☐ Negative

If PPD POSITIVE, date of last Chest X-ray: ____________

If POSITIVE in the past, are you having any of the following symptoms (check box)?

☐ Fever ☐ Chronic cough ☐ Bloody sputum ☐ Weight loss ☐ Shortness of breath

Student Signature_________________________________________________________________

My signature above indicates that the above information is true and accurate to the best of my knowledge.

**Thank you**

**Please bring this form with you at the time of your appointment**

College of Charleston
Center for Student Wellness
Student Health Service
181 Calhoun Street
Charleston, SC
Phone: 843-953-5520 Fax 843-953-6377

***This page will be completed by College of Charleston Student Health Service Staff***

Name________________________College ID #__________________Date______________

**SCREENING DISPOSITION**

☐ **Reviewed**

☐ **Needs educational materials:**

☐ **Needs Immunizations:**

☐ **Needs Additional Clinician Visit**

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**The above-named student met with me on ____________________ . He/she has been immunized against Tetanus within the last ten years and will remain current for at least the next twelve (12) months. He/she has also been screened for Tuberculosis within the last twelve (12) months.**

**Students who have been determined to be at additional risk have been counseled and advised by a physician regarding those risks.**

______________________________________________________________________________

Health Care Provider Printed Name Date