Marian University IACUC

Medical Clearance for Animal Care & Handling

### Note to applicant: This must be completed prior to working with animals and when any changes in medical conditions or animal exposure intensity occur. SIGN AND EMAIL THE COMPLETED FORM TO Healthservices@marian.edu.

### Note to medical staff: return medical clearance recommendation (page 3) only to iacuc@marian.edu.

Name: (Last)       (First)

Status: [ ]  Faculty/staff [ ]  Student [ ]  Other:

Campus/home Mail Address:       City:       State:       Zip Code:

Phone #: (     )      -      E-mail Address:

Department/College:

Birth Date:       Gender: [ ] Male [ ]  Female [ ]  Non-binary/Other

Race/Ethnicity: [ ] Asian [ ] Black [ ] Hispanic [ ] White/Caucasian [ ] Other

Personal Physician: Name:      Telephone number: (     )      -

**Unit where employed or where handling animals:**

[ ]  Marian Hall [ ]  Field Only [ ]  Other

**Please check all circumstances that apply.** (“Contact” means direct handling or care)

[ ]  Contact with vertebrate animals.

Specify: Common names:

[ ]  Field work with vertebrate animals.

Specify: Common name:

[ ]  Contact specifically with carnivorous wild caught mammals. (Vaccination declination is on a separate form to be provided by the medical staff upon determination of need)

Specify: Common name:

[ ]  Contact with animal tissues/fluids not treated with chemical preservatives.

[ ]  No direct animal contact, but working in the same facility with animals or their non-preserved tissues.

Estimate animal contact in **hours per week**:

Estimate non direct animal contact time in **hours per month**:

**Have you had a tetanus booster in the past 10 years?**

[ ]  Yes (Attach documentation)

[ ]  No (Current tetanus required and may be obtained from the Student Health Center at no cost to the animal user.)

**Medical History**

**Do you have any current medical problems?** [ ] Yes [ ]  No

If yes, explain:

**Do you have any chronic medical problems?** [ ] Yes [ ]  No

If yes, explain:

**Have you had any of the following?** (Check all that apply and **indicate when**)

[ ] None [ ] Pneumonia [ ] Restriction on lifting limit       Specify lbs

[ ] Recurrent Bronchitis [ ] Arthritis [ ] Chronic Back or Joint Pain [ ]  Heart Disease

[ ] Carpal Tunnel Syndrome or Repetitive Motion Injury

**Allergy History:**

**List all medications that you are presently on.** (Especially all asthma/allergy medications including inhalers)

[ ]  none

List any allergies to medications:

[ ]  none

**Do you have any of the following symptoms or conditions?** (Check all that apply that **are not associated with a cold**.)

 [ ]  Chronic cough [ ]  Asthma

 [ ]  Skin rash [ ]  Chronic allergies (food, mold, dust)

 [ ]  Runny nose, sinus congestion [ ]  Itchy, irritated eyes

 [ ]  Shortness of breath/wheeze [ ]  Hay fever or other environmental seasonal allergies (pollen)

 [ ]  None

**Are you allergic to any of the following?** (Check all that apply)

 [ ]  Mice [ ]  Rats [ ]  Rabbits [ ]  Raptors/Birds [ ] Weed [ ]  Trees

 [ ]  Grass [ ]  Latex [ ] Food [ ]  Pollen [ ]  Dogs [ ]  Cats

 [ ]  Other:

[ ]  None

[ ]  I would like to be seen by the medical staff. (See appointment instructions below.)

**Please be informed that 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 your work.**

**Other conditions:**

**I agree to have the above information reviewed by the appropriate party listed on the next page. I understand that additional vaccinations may be recommended by the health care provider. Cost of the animal handler review at Health Services will be charged to the Office of Research & Scholarship. If I have taken this document to my personal physician, I understand that I am responsible for all associated costs:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature Date**

**Clearance Recommendation Page**

###  Patient's Consent and Authorization

***Note to medical staff: THIS PAGE ONLY should be returned to*** ***iacuc@marian.edu*** ***and to the patient.***

***The remainder of this document should remain in the patient’s medical record at the medical facility.***

I consent to and authorize **Health Services** to release my approval status for work with animals and any applicable restrictions to Marian University Institutional Animal Care and Use Committee. I understand this consent is revocable except to the extent action has already been taken. Further disclosure or release of my health information is prohibited without specific written consent of person to whom it pertains.

|  |  |
| --- | --- |
| Print Patient Name:       | \*Patient Email Address:       |
| **Status: [ ]  Faculty/staff** **[ ]  Student – Animal research/teaching faculty adviser full name:**      **[ ]  Other**  |
| Patient’s signature | Date: |

### Medical Staff Recommendations:

**(Choose one)**

|  |  |
| --- | --- |
| [ ]  | I am not aware of any contraindications toward participation in animal care or handling. |
| [ ]  | Physical examination or vaccination required. Please make an appointment. |
| [ ]  | I believe the applicant can participate in animal care or handling with the following restrictions:      |
| [ ]  | I recommend the applicant **not** participate in animal care or handling. |
| [ ]  | Applicant must seek medical clearance from a personal physician. |

### (Choose one)

|  |  |
| --- | --- |
| [ ]  | Re-evaluation required when any changes in medical conditions or animal exposure intensity occur |
| [ ]  | Re-evaluation required upon immunization expiration date: **[Enter expiration date:**      ] |

### (Choose one)

|  |  |
| --- | --- |
| [ ]  | The reviewing practitioner is aware that mammal species are involved in this research/teaching activity. |
| [ ]  | Mammals are not involved in this research/teaching activity. |

|  |  |
| --- | --- |
| \*Practitioner’s signature | Date: |
| \*Practitioner’s name (print) | Phone: | Email: |
| **[ ]** Marian University Student Health **[ ]** Other (Provide clinic address below)  |  |
| \*Clinic Address: | City:  | State & Zip: |