The College of New Jersey
Animal Research Medical Monitoring Questionnaire

Name:_____ TCNJ ID#_____

TCNJ Email:_____ Date of Birth_____ Gender:_____

Protocol #_____

Add your name and TCNJ ID # to all pages

Work Status: (check only one)

- TCNJ EMPLOYEE: Full-time or part-time employee with job duties in animal facilities OR animal research in their job description.

  _____FACULTY _____STAFF _____STUDENT EMPLOYEE

- _____STUDENT RESEARCHER: A student works with vertebrate animals but is not employed by TCNJ.

What is your role?

_____I am not handling animals, but will be working in areas where animals are housed.

_____I will handle or have regular contact with animals.

Indicate the animals you will be handling or having regular contact with (check all that apply):

___Mice (Laboratory)	___Snakes (Non-Venomous)	___Fish
___Mice (Wild)	___Snakes (Venomous)	___Birds
___Rats (Laboratory)	___Amphibians	___Reptiles

Other (identify):_____

Describe your duties as they pertain to your potential exposure to these animals:_____

_____

Who is your Research Supervisor / Principal Investigator?_____

To meet the requirements of the IACUC Occupational Health & Safety Program, The College of New Jersey is required to obtain an initial medical evaluation and clearance for all personnel whose job duties or academic work bring them in direct contact with animals and animal research. Following the required initial medical evaluation, on an annual basis EHS will contact all Principal Investigators to offer a subsequent (referred to as an "annual") medical evaluation. All medical evaluations are offered at no charge to TCNJ personnel.

Indicate your medical evaluation and clearance status (you must select one), then complete the Medical Surveillance Questionnaire (beginning on page 3):

_____**Initial**
For all NEW faculty, staff, student workers and student researchers, and returning personnel with a change in research duties.

_____**Follow-Up**
For faculty, staff, or student workers that have previously been medically cleared (such as during the initial medical evaluation).

Name: _____ TCNJ ID#_____

Reviewing Healthcare Provider, after review:

- *Return to TCNJ: Pages 1 & 2*
  - *Research/Protocol Information and Reviewing Healthcare Provider determination*
- *Do NOT return to TCNJ: Pages 3 & 4*
  - *Medical Surveillance Questionnaire (has personal information)*

This section is to be completed by the Reviewing Healthcare Provider

I have reviewed the examinee's form, and based on the responses:

___Examinee may perform the functions of their research with no medical restrictions.

___Examinee may not perform the functions of their research.

___Examinee may perform the functions of their research with specific limitations or accommodations.

___Examinee must receive a follow-up examination from their primary physician or healthcare provider, prior to working with animals.

Recommendations:

_____

_____

_____

_____ _____

Healthcare Provider's Signature Date

_____

Healthcare Provider's Name (Print)

Office Address: _____

Office telephone #:_____

TCNJ Employee Medical Monitoring File (Confidential) for all Faculty, Staff, and Student Workers will be maintained securely by Environmental Health and Safety, Maintenance Building

TCNJ Student Medical Records (Confidential) for all Student Researchers will be maintained securely by Student Health Services. Upload the completed form to OWL at https://tcnj.medicatconnect.com.

Name: _____ TCNJ ID#_____

MEDICAL SURVEILLANCE QUESTIONNAIRE

Instructions: Answer all questions
Do not return the completed form to a TCNJ employee

Immunizations:

Provide the date(s) you received the following vaccinations. If you do not know the date of vaccination, write "Received" to indicate you have received the immunization. If you are unsure if you have received this immunization, write "Unknown".

Hepatitis A	Hepatitis B	Tetanus Booster
Dose #1:_____	Dose #1:_____	Most Recent:_____
Dose #2:_____	Dose #2:_____	
Or, laboratory test for immunity:_____	Dose #3:_____	
	Or, laboratory test for immunity:_____	

Allergy History:

1. Are you allergic to any medicines? ___Yes ___No
   If Yes, list the name of the medicine and describe your reaction:_____
   _____
2. Do you have any of the following? (check all that apply)
   ___Chronic cough ___Chronic allergies (list):_____
   ___Itchy, irritated eyes ___Hay fever ___Skin rash
3. Do you have a history of asthma? ___Yes ___No
   If Yes, provide details (when does it occur, what triggers it, how it is managed & controlled):
   _____
   _____
4. Do you use any medicine for your asthma? ___Yes ___No
   If Yes, list the name(s) of the medicine(s) and how often you use them:_____
   _____
5. Have you ever experienced any of the following symptoms associated with animal contact (check all that apply, and note the type of animal):
   ___Sneezing ___Runny Nose ___Itchy, watery eyes ___Itchy skin
   ___Rash ___Hives ___Shortness of breath ___Wheezing
   ___Chest tightness ___Cough ___Anaphylaxis ___None
   List Animals:_____

Name: _____ TCNJ ID#_____

6. Are you allergic to any of the following? (check all that apply)

___Dogs ___Cats ___Cattle ___Horses ___Birds (feathers)

___Hogs ___Primates ___Rabbits ___Goats ___Sheep (wool)

___Guinea Pigs ___Mice ___Rats ___Latex ___Grasses

___Trees ___Weeds ___Alfalfa ___Insect stings/bites

___Chemicals (list):_____

___Other (list):_____

___No allergies

If you checked one or more of the above (except "No Allergies"), elaborate by describing your reaction and what you do for it:_____

_____

7. Do you have any skin problems, such as reactions to latex, dry/cracked skin, rashes? ___Yes ___No
If Yes, describe:_____

_____

Medical Factors:

1. In the last three months, have you taken any medications which might suppress your immune system (e.g. prednisone, cortisone, chemotherapy, methotrexate, etc.)? ___Yes ___No

2. Do you have any chronic medical conditions that might suppress your immune system (e.g., cancer, leukemia, lymphoma, diabetes, HIV or AIDS, tuberculosis, liver or kidney disease, alcoholism)?
___Yes ___No If Yes, specify condition:_____

_____

3. In the past year, did you develop any new medical problems? ___Yes ___No
If Yes, describe:_____

_____

For Females:

1. Are you pregnant? ___Yes ___No

2. Are you planning on becoming pregnant within the next year? ___Yes ___No

Note: Alert the Office Environmental Health and Safety if or when you do become pregnant. This may impact your research duties, and must be taken into consideration when performing research under certain protocols.

ATTESTATION – read, date, and sign

I have answered the questions on this form truthfully, and to the best of my recollection. The Institutional Animal Care and Use Committee (IACUC) may be informed only of the date of evaluation to verify my participation in the program, and whether or not I may continue to work with laboratory animals (or any restrictions in doing so).

_____ _____

Applicant's Signature Date