Binghamton University
Animal Users Health and Safety Screening

HEALTH SCREENING FORM

Name:
B number:
E-mail address:
Preferred contact number (include area code):
Please indicate how UHS can contact you for recommendations: □ Phone □ E-mail
PI or Supervisor or Instructor:
Facility where research/animal exposure occurs:
Date of Birth:

A. ROLE □ Staff □ Faculty □ Student

B. ANIMAL SPECIES YOU INTEND TO WORK WITH
□ Rat □ Mouse □ Amphibian □ Rabbit □ Bird □ Other

C. IMMUNIZATIONS:
Are you current with your Tetanus immunizations? (Note: Tetanus immunizations are recommended every 10 years)
□ Yes □ No □ Unknown
What is the date of your last Tetanus immunization?
Any additional information:

D. ALLERGIES / ASTHMA / SKIN PROBLEMS
1. Are you allergic to any animals?
□ Yes □ No
If yes:
   Have you had these animal allergy symptoms within the past 12 months?
□ Yes □ No
Are the level of these allergy symptoms severe or life threatening?
☐ Yes  ☐ No

Please list the animal(s) and their associated allergy symptoms:

What animal allergy treatment are you currently using?

2. Are you allergic to any environmental allergens such as grass, trees, pollen, dust?
☐ Yes  ☐ No
If yes:

Have you had these environmental allergy symptoms within the past 12 months?
☐ Yes  ☐ No

Are the level of these allergy symptoms severe or life threatening?
☐ Yes  ☐ No

Please list environmental allergens and their associated allergy symptoms:

What environmental allergy treatment are you currently using?

3. Do you have asthma?
☐ Yes  ☐ No
If yes:

Have you had asthma symptoms within the past 12 months?
☐ Yes  ☐ No

Are the level of these asthma symptoms severe or life threatening?
Please describe your asthma triggers (if known):

What asthma treatment are you currently using?

4. Do you have allergy or asthma symptoms specifically related to your work?
   □ Yes    □ No
   If yes:
   Have you had these symptoms within the past 12 months?
   □ Yes    □ No

   Are the level of these symptoms severe or life threatening?
   □ Yes    □ No

   Please describe your allergy or asthma symptoms at work.

   What treatment are you currently using for your work-related allergy or asthma symptoms?

5. Have you had any skin problems caused or exacerbated by your work activities?
   □ Yes    □ No
   If yes:
   Have you had this skin problem within the past 12 months?
   □ Yes    □ No

   Are the level of these skin problems severe or life threatening?
   □ Yes    □ No
Please describe the skin problem.

What skin problem treatment are you currently using?

E. INCREASED RISKS

1. Pregnancy Risk  (*Some research-related or animal biohazards have adverse effects on pregnancy.*)

   Are you pregnant or planning to become pregnant in the next year?
   
   □ Yes  □ No  □ Not Applicable

2. Compromised Immunity Risk  (*Some research-related or animal biohazards may create an increased risk for individuals who are immunocompromised.*)

   Are you immunocompromised due to certain diseases (such as cancer, lupus, rheumatoid arthritis, HIV) and/or their treatment (such as steroids, radiation therapy, chemotherapy)?

   □ Yes  □ No

F. ILLNESS/CONDITIONS DURING PAST 12 MONTHS

   Symptoms of some research-related or animal-related illnesses may not be immediately recognized. Please specify if you’ve experienced any of the following:

   □ Chronic Cough  □ Wheezing  □ Night-time Cough
   □ Itchy or Irritated Eyes  □ Hives  □ Skin Rash
   □ Heart Conditions  □ Lyme Disease  □ Eczema
   □ Chronic Muscle or Joint Problems

   Please describe illness/condition and treatment:

To the best of my knowledge, the information included herein is true.

Name (please print): _________________________________ Date of Birth: ______________

Signature: ___________________________________________ Date: ____________________
Please note: If you have any change in your health (e.g., pregnancy, immunocompromised status, new allergies), please submit a revised health screening form for review.

Reviewed by:                               Date: