Employee Health Package

Updated November 17th, 2021

Instructions

If you are participating in any VHA research activity, please fill out the following forms in their entirety and follow the below instructions.

1. Please complete and sign all forms as indicated.
2. Employees who are **NOT** participating in animal research **ONLY** need to complete the Immunization page.
3. Please SAVE a copy of this information for your records.
4. Print off the completed forms and bring to your Employee Health Appointment with you.
5. **DO NOT RETURN ANY OF THESE FORMS TO ZHOIE BIGHAM OR ANY RESEARCH OFFICE PERSONNEL.**

Confidential Medical Information (when filled in)

Significant Biological Agent or Animal Contact Health Surveillance Questionnaire

Name:________________________________ SSN: _____________________________

Service: ______________________________ Date of Birth: _______________________

Gender: ______________________________ Phone: ____________________________

Email: _______________________________ Preferred Language: ________________

Projected Duration of Duties: ____

Previous Evaluation at Employee Health? _______________________________________

Status (Check all that apply):

- ☐ VA Staff
- ☐ UM Faculty
- ☐ WOC
- ☐ Animal Handler
- ☐ Veterinarian
- ☐ Research Technician
- ☐ Research Assistant
- ☐ Other (Specify): _______________

Allergy History

List any allergies to medications: ____

List reactions to medications: ____

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

- ☐ Chronic Cough
- ☐ Hay Fever
- ☐ Skin Rash
- ☐ Asthma
- ☐ Allergic Rhinitis (runny nose)
- ☐ Allergic Conjunctivitis (itchy, watery eyes)
- ☐ Chronic Allergies (food, pollen, dust)
- ☐ Natural Parent and/or sibling with allergies to animals or their substances

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

☐ Dogs	☐ Rats or Mice	☐ Birds (feathers)	☐ Primates	☐ Wood
☐ Cats	☐ Rabbits	☐ Farm Animals	☐ Latex	☐ Other:__________
☐ Swine	☐ Guinea Pigs	☐ Sheep (wool)	☐ Chemicals	
☐ Alfalfa	☐ Trees	☐ Weeds	☐ Grasses	

Do you have any of the following symptoms that you feel are caused by, or made worse, because of your work with laboratory animals?

- [ ] Cough
- [ ] Wheezing
- [ ] Chest Tightness
- [ ] Hives
- [ ] Sneezing
- [ ] Shortness of Breath
- [ ] Rash
- [ ] Runny Nose
- [ ] Watery, burning or itchy eyes

Other Health Information

Have you been told by a physician that you have an immune compromising medical condition or are taking medications that impair your immune system (steroids, immunosuppressive drugs, chemotherapy)?

If yes, list medications/conditions: ____

Are you currently pregnant or plan to become pregnant within the next year? ___________

List any other conditions, medications, or concerns the provider should know about.

I verify that all information is accurate and that I have referred to and read all pertinent information related to the animals that I come in contact with.

Signature: ____

Date:_____________________________

SSN: ______________________ Name:________________________

Immunization Record – All staff must complete!

Enter the date of most recent vaccination/booster/blood test. Enter 'ND' for never doneif the vaccination or test was never performed. Enter '?' if you have had the vaccination/test but cannot recall the date.

Measles:________________________

Mumps:________________________

Rubella:________________________

Tetanus:________________________

Rabies:________________________

Q Fever:________________________

CMV:________________________

Hepatitis A:________________________

Hepatitis B:________________________

Smallpox (Vaccinia):________________

Yellow Fever:_____________________

Toxoplasmosis:____________________

BCG:____________________________

Varicella (Chickenpox):______________

Tuberculosis/PPD Skin Testing:__________________________

If positive, date of last chest x-ray:________________________

If positive in the past, are you having any of the following symptoms? (Check all that apply)

☐ Fever ☐ Chronic Cough ☐ Shortness of breath ☐ Bloody Sputum ☐ Weight Loss

COVID-19 Vaccine:

	Dose 1	Dose 2	Dose 3
Date received:			
Manufacturer of COVID-19 vaccine (Pfizer, Moderna, etc)			
Lot number			