AMHERST COLLEGE

Occupational Health and Safety Medical Questionnaire

Name: ____ **Date:** ____ / ____ / __________

E-Mail: ____ **Cell #:** (____) _____ - _________

Department: ____________________________________

Faculty Responsible: _____________________________

While at Amherst College, I will be working with the following; ___ **Fish** ___ **Fruit Flies** ___ **Rats** Other: _____________

- Have you ever worked with the above in the past? **Y** **N**
- What type of contact will you have? __ No direct contact __ < 8 hrs/week __ > 8 hrs/week

Medical History (Please check all of the applicable boxes below)

__ Asthma __ Arthritis __ Bronchitis __ Cancer __ Diabetes __ G.I. Issues __ Heart Issues __ Kidney Disease
__ Liver Disease __ Pain (Chronic Back or Joint) __ Pneumonia __ Rheumatic Fever __ Seizures __ Tuberculosis

Have you been diagnosed by a physician as having an immune compromising medical condition? **Y** **N**

Are you taking any of the following medications (chemotherapy / immunosuppressive / steroids)? **Y** **N**

Are you currently taking medications? **Y** **N**

- List medications currently being taken; ____

What vaccinations have you had? __ Flu (w/in 1 year) __ Hepatitis __ Rabies (w/in 7 years) __ Tetanus (w/in 10 years)

- List additional immunizations you have had; ____

If you are pregnant, or planning to become pregnant within the next year **Y** **N**

- Do you understand the risks of working with anesthetics, animals, hazardous agents / chemicals? **Y** **N**

Allergy History

Do you have allergies? **Y** **N**

I have allergies to; __ Animals __ Cats __ Dogs __ Dander ___ Grass/Weeds __ Latex __ Mold __ Rodents __ Trees

- List any other allergies you have; ____

What allergy medication do you take? ____

Have you ever needed to use an inhaler to control or prevent wheezing or other respiratory issues? **Y** **N**

Would you like to consult with a physician prior to working with fish, fruit flies, rats or other identified research? **Y** **N**

- I am aware that it will be my responsibility to identify to my professor any known or potential future illness or injury that I feel may be contracted through my work with the above research.

The information above is complete and accurate to the best of my knowledge. I understand that this questionnaire will be used solely for internal review to best protect my health and wellbeing, and that it will not be released without my written permission.

_______________________________ _______________________________

Signature of Participant Signature of Faculty Member

Amherst College Review

Medical Review Required **Y** **N**

Medical Review to be performed by; Health Services AEIOU Occupational Physician Other: ____________________

Personal Protective Equipment Required

__ Safety Glasses __ Safety Goggles __ Lab Coat __ N95 Mask __ Respirator __ Other: ______________________

When this form is completed, please email to rameats@amherst.edu