



# Haverford College

## Laboratory Animal Research Risk Assessment Questionnaire

### Part A: Personal Data

Preferred name: \_\_\_\_\_ Gender: \_\_\_\_\_ Age: \_\_\_\_\_

Email: \_\_\_\_\_ Telephone: \_\_\_\_\_

Mailing address: \_\_\_\_\_

Building and number of the room in which you will primarily interact with animals: \_\_\_\_\_

For students: Provide evidence of current tetanus vaccination to your supervisor; complete Parts B, C, D, E, F; have your supervisor sign below; then complete Parts G and H.

Name of your faculty or staff supervisor (if you are a student): \_\_\_\_\_

Signature of supervisor: \_\_\_\_\_ Date signed \_\_\_\_\_

Signature of supervisor above certifies receipt of evidence of a current tetanus vaccination and agreement with the accuracy of the information provided in Part B, Part C1, Part D, Part E, and Part F.

Your signature certifies that the information you provided is accurate and that you will update it promptly.

Your signature: \_\_\_\_\_ Date signed \_\_\_\_\_

### Part B: Your interaction with the animals. Check one of the following:

\_\_\_\_\_ I only enter rooms in which animals are kept. I do not handle animals, their tissues or body fluids, or animal products. (If you checked this, please skip to part E.)

**-OR-**

\_\_\_\_\_ I enter rooms in which animals are kept and observe procedures being performed by my supervisor or, with my supervisor's permission, by students named on an approved protocol, but I do not handle animals, their tissues, or body fluids. (If you checked this, please skip to Part D.)

**-OR-**

\_\_\_\_\_ I am involved with animal research or maintenance. (If you checked this, please complete the rest of this section.)



**C5.** Do you experience any of the above symptoms when you are exposed to research animals in the research facility? Yes No

If “yes,” please list the animal and the symptoms experienced:

**C6.** Do you have a known allergy to any animals (pet, research, or other)? Yes No

If “yes,” please list the animal(s) and the symptoms you experience when exposed to them:

**Part D: Exposure to hazardous agents.**

**IMPORTANT:** For each of the following, please respond “yes” only if you use the agent in rooms where live animals are housed, handled, or experimented with. If you are working under the supervision of a faculty member doing animal research at Haverford or the Rodent Facility Manager, please check with your supervisor that you have listed all of the hazardous agents to which you are exposed.

**D1. Biosafety:** I use infectious agents, recombinant vectors, or toxins: Yes No

If “yes,” please list agent and indicate frequency of use (several times per day, week, month, or year):

1. Agent: \_\_\_\_\_ Frequency of use: several times per \_\_\_\_\_
2. Agent: \_\_\_\_\_ Frequency of use: several times per \_\_\_\_\_
3. Agent: \_\_\_\_\_ Frequency of use: several times per \_\_\_\_\_
4. Agent: \_\_\_\_\_ Frequency of use: several times per \_\_\_\_\_

**D2. Chemotherapy agents:** I use antineoplastic agents (chemotherapy agents): Yes No

If “yes,” please list agent and indicate frequency of use (several times per day, week, month, or year):

1. Agent: \_\_\_\_\_ Frequency of use: several times per \_\_\_\_\_
2. Agent: \_\_\_\_\_ Frequency of use: several times per \_\_\_\_\_
3. Agent: \_\_\_\_\_ Frequency of use: several times per \_\_\_\_\_
4. Agent: \_\_\_\_\_ Frequency of use: several times per \_\_\_\_\_

**D3. Other hazardous chemicals:** I use hazardous chemicals other than antineoplastic agents: Yes No

If “yes,” please list chemical and indicate frequency of use (several times per day, week, month, or year):

1. Chemical: \_\_\_\_\_ Frequency of use: several times per \_\_\_\_\_
2. Chemical: \_\_\_\_\_ Frequency of use: several times per \_\_\_\_\_
3. Chemical: \_\_\_\_\_ Frequency of use: several times per \_\_\_\_\_
4. Chemical: \_\_\_\_\_ Frequency of use: several times per \_\_\_\_\_

**D4. Other hazards:**

List other hazards in your workplace and frequency of exposure (several times per day, week, month, or year):

- 1. Hazard: \_\_\_\_\_ Frequency of exposure: several times per \_\_\_\_\_
- 2. Hazard: \_\_\_\_\_ Frequency of exposure: several times per \_\_\_\_\_
- 3. Hazard: \_\_\_\_\_ Frequency of exposure: several times per \_\_\_\_\_
- 4. Hazard: \_\_\_\_\_ Frequency of exposure: several times per \_\_\_\_\_

**Part E: Personal protective equipment**

I use the following protective equipment in rooms where live animals are housed, handled, or experimented with (check all that applies):

- Disposable gown                       Respirator (Type: \_\_\_\_\_ Have you been fit tested? Yes No)
- Disposable shoe coverings             Eye protection                       Gloves
- Hearing protection                       Surgical mask  with or  without face shield

**Part F: Immunizations**

**F1.** I have had a tetanus vaccine within the last 10 years: Yes No

If yes, please give the date of your most recent vaccine: \_\_\_\_\_

**Part G:**

**G1.** Do you have any questions or concerns regarding your work with animals that you would like to discuss with a nurse practitioner? Yes No

**G2.** Please add any remarks you feel are relevant.

**Part H: Medical History** (This information is confidential, so please fill it out in private.)

**H1:** Do you have any of the following health considerations? (Check all that apply)

- Asthma or other chronic respiratory disease
- Skin conditions such as eczema, psoriasis, dermatitis
- Allergic skin reaction such as hives, rash, itches. (Explain : \_\_\_\_\_)
- Known or suspected allergies to chemicals, latex, food, or environment (explain : \_\_\_\_\_)
- Chronic health conditions such as diabetes (explain : \_\_\_\_\_)
- Kidney or liver disease
- Valvular heart disease
- History of spleen problems or absence of spleen
- Pregnant or planning to become pregnant
- Immune system deficiency or other limitation to your ability to fight off disease or infection; for example, cancer, lupus, organ transplant, HIV infection, chronic infections (list : \_\_\_\_\_)
- Current medication or treatment that may suppress your immune system; for example, high-dose steroids, prednisone, cancer therapy or radiation therapy (list : \_\_\_\_\_)

Please deliver your completed form to your primary care provider if you are a faculty or staff member. **If you are a student, please deliver your form to Healthcare Provider in Haverford's Health Services or Healthcare Provider in Bryn Mawr's Health Center for evaluation.** That medical professional will let the chair of Haverford's Animal Care and Use Committee (Rebecca Compton, [rcompton@haverford.edu](mailto:rcompton@haverford.edu)) know whether you are:

- (1) Medically eligible to perform the stated activities without restriction
- (2) Medically eligible to perform the stated activities with additional requirements (e.g. respiratory protection or vaccination), or
- (3) deemed medically ineligible to perform the stated activities

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