Biosafety Level 2 (BSL-2) Research Medical Eligibility Form

Instructions:

• Student must make an appointment with the Health Services (610-896-1089). Note: assume at least 2 weeks’ time frame to complete any necessary medical exam, laboratory tests or required immunizations;
• Student must complete this form prior to arrival for assessment of medical eligibility. Go to www.haverford.edu/healthservices under “forms” to download an electronic copy. Staff members filling out this form should share this form with their primary care provider.
• After medical clearance is received, student must complete lab safety training with Research Supervisor;
• No student is to work in the laboratory until medical clearance is given by the health care provider at Health Services and lab safety training is complete to the satisfaction of Research Supervisor;
• If a student is exposed to any hazard in the laboratory it is the responsibility of the student and the Research Supervisor to report the incident immediately to the Coordinator of Campus Safety (Mark Sweeney, msweeney@haverford.edu (610-896-1111) and refer to the emergency room as appropriate;
• Student must provide a completed copy of Sections A-C (pages 1-3) of this form to the Research Supervisor.

Part A: Personal Data (to be completed by student or laboratory employee, and signed by Research Supervisor)

Preferred name: ___________________________ Are you 18 or older?: ___ Yes ___ No
Email: ___________________________ Telephone: ___________________________
Mailing address: __________________________________________________________
Building name and room number(s) in which you will be working: __________________________

Your signature: ___________________________ Date ___________________________

Name of your Research Supervisor: ___________________________

Signature of Research Supervisor: ___________________________ Date ______________
Part B: Exposure to hazardous agents (to be completed by student or laboratory employee in consultation with Research Supervisor)

IMPORTANT: For each of the following, please respond “yes” only if you use the agent in rooms. If you are working under the supervision of a faculty member doing research at Haverford; please check with your supervisor that you have listed all of the hazardous agents to which you are exposed.

B1. Nature of your contact with BSL2 materials: Which of the following best describes your exposure to hazardous agents?:

____ I will be using hazardous materials as part of my BSL2 work

____ I will be working in the research lab where hazardous materials are present but I will not have direct contact with these materials

____ I will be working in an adjacent lab to the lab where BSL2 procedures will be carried out, and will have limited exposure to hazardous materials associated with BSL2 procedures (you may skip Part B if your Research Supervisor approves)

B2. 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___________

B3. 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___________

B4. 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___________
B5. 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 C: To be completed by the Healthcare Provider at Haverford College or Bryn Mawr College

Preferred name of student: _______________________________

These reports have been submitted and reviewed as noted by check:
___ Report of Medical History and Clinical Record
___ Current immunization status
___ Listed Exposures

Costs incurred due to meeting medical eligibility requirements (such costs will be borne by the relevant academic department in consultation with Health Services): $____

Student Status as noted by check:
___ Medically eligible to perform the stated activities without restriction
___ Medically eligible to perform the stated activities with additional requirements as noted:
____________________________
___ Deemed Medically NOT eligible to perform the stated activities

______________________  ______________________  _____________
Health Care Provider (printed)  Health Care Provider (signature)  Date

Please detach Sections A-C (pages 1-3) above and submit these Sections to the Research Supervisor.
To be completed by student or laboratory employee.

The following information is confidential, and will be reviewed only by Health Services. Please detach this section before providing the information contained above to Research Supervisor.

Part D: Immunizations

D1. I have had a tetanus vaccine within the last 10 years: ___ Yes ___ No Date: __________

D2. All my immunizations are up to date: ____ Yes ____ No- if No, will complete by ______

D3. I want to accept _______ decline ______ a prescription for pneumococcal vaccine.

Part E:

E1. Do you have any questions regarding your work that you would like to discuss?

E2. Please add any remarks you feel are relevant. ________________________________

Part F: Medical History

F1: Do you have any of the following health considerations? (Check all that apply)

___ Asthma or other chronic respiratory disease
___ Cardiac disease
___ Hypertension
___ Chronic health conditions such as diabetes (Explain: _____________________________)
___ Kidney or liver disease
___ Valvular heart disease
___ History of spleen problems or absence of spleen
___ Deafness
___ 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 _____)
___ 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 (please list _____________________________)

___ Current medication or treatment that may suppress your immune system; for example, high-dose steroids, prednisone, cancer therapy or radiation therapy (please list: ______________________________________)
___ Other

Note: For employees, please deliver your completed form to your primary care provider.

RF: 11_18_2020