HAVERFORD COLLEGE

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