

UTSA OCCUPATIONAL HEALTH PROGRAM

Risk Assessment & Initial Enrollment Form

Last Name _____ First Name _____ Middle Name _____ Date of Birth _____
 Gender ☐ Male ☐ Female Department _____ Supervisor/PI _____
 Job Title _____ Work phone _____ Cell Phone _____ E-Mail _____
 Campus Bldg/Office Location _____ Room # _____ My UTSA ID #: (abc123) _____
 (i.e BSB/ FSA)

Vaccination History (Please attach supporting immunization documentation)

Hepatitis A _____ Hepatitis B _____ Influenza _____
 Rabies (Rabavert) _____ Tetanus _____ PPD (TB Skin Test) _____
 Chickenpox (Varicella) _____ MMR _____
 Tetanus, Diptheria, Pertussis (DPT/Tdap) _____

			If yes, Describe
Do you work with formaldehyde?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Do you work with human or non-human primate blood, tissue or cells?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Do you work with any infectious agents (i.e., bacterial, viral, fungal, parasitic)?...	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Do you work with biological toxins (i.e., botulism, conotoxin, tetrodotoxin)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Do you work with anesthetic gases (i.e., isoflurane)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Do you work with anti-neoplastic drugs?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Do you work with carcinogens (i.e., benzene, chloroform, dichloromethane).....	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Do you work with highly toxic chemicals?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Do you work with heavy metals (i.e., copper, chromium, lead, lithium)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Do you work with reproductive hazards (mutagens/teratogens)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Are you exposed to animal waste (carcasses, feces, urine, tissues)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Are you exposed to needles/scalpels/sharps?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Do you wear a respirator in your work?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Do you cut metal by torch or weld > 20 days/year?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Are you allergic to latex?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
List Animals, Insects or Plants			
Do you have close, recurring contact with animals during your work?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Do you have contact with insects during your work?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Do you have close, recurring contact with potentially harmful plants or fungi ?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____

Acknowledgment Statement

- I have reviewed the information concerning the UTSA Occupational Health Program (OHP) posted on the People Excellence OHP web page.
- I understand that working directly or indirectly with animals, or exposure to biological, chemical or physical hazards may pose certain health risks. I have been advised to complete the OHP Health Assessment in order to provide the Licensed Health Care Provider (LHCP) with a complete medical history.
- I understand that tests or immunizations for my job function / area may be mandatory for full participation in the OHP and that proof of test or immunizations may be needed to meet program requirements.

In full recognition of the above statements please check one of the following 2 participation choices:

I accept participation in the UTSA OHP Health Assessment, and I will complete the UTSA OHP Health Assessment form

I decline participation in the UTSA OHP Health Assessment at this time, and I will review and sign the OHP Health Assessment Declination form that will be given to me by the Occupational Health staff.

I have read, understood, and answered all parts of this form truthfully, and to the best of my ability and knowledge.

Signature _____

Date _____

**THE UNIVERSITY OF TEXAS AT SAN ANTONIO
HEPATITIS B VACCINATION DISCLOSURE FORM**

Name (Please Print): _____ Department _____ Supervisor _____

Date of Birth: ____/____/____ UTSAID: _____ Job Title _____ Phone(work/cell) _____

Email: _____

As a result of the nature of my occupational duties at UTSA, there is a substantial risk of direct contact with blood or other potentially infectious materials which have been determined as likely to transmit the Hepatitis B virus. I have received Bloodborne Pathogen Training and am aware of the precautions that must be taken when dealing with blood and body fluid exposure. As part of UTSA's Bloodborne Pathogen Exposure Control Plan and as a covered employee under UTSA's Occupational Health Program, I can receive vaccination against Hepatitis B at no cost.

INSTRUCTIONS: Place a ☒ in either A, B or C box below that best describes your intent.

☐ **A** Yes, I'd like to get a Hepatitis B vaccine
Call Ext.5304 or e-mail UTSAohp@utsa.edu to schedule an appointment.

CONSENT FOR HEPATITIS B VACCINE. In accordance with UTSA's Bloodborne Pathogen Exposure Control Plan, I am being offered, free of charge, the Hepatitis B vaccination. The vaccine will be administered during working hours.

1. I have never received the Hepatitis B vaccine and would like to be vaccinated.
2. I have been informed that I am at risk of acquiring hepatitis B because of the nature of my professional responsibilities.
3. I have read the information sheet that lists the indications, benefits, and presently known side effects of Hepatitis B vaccine, have had an opportunity to ask questions, and have had them answered to my satisfaction.
4. I must receive three (3) doses of vaccine over a period of six (6) months to confer optimal immunity.
5. I understand, however, as with all medical treatment, there is no guarantee that I will become immune or that I will not experience an adverse reaction to the vaccine.
6. In the event that I should terminate employment at UTSA prior to receiving all three (3) doses of Hepatitis B vaccine, I understand that it will be my responsibility to complete the vaccination series on my own initiative and at my own expense.

Employee Signature: _____ Date: _____

☐ **B** I already received the Hepatitis B.

PREVIOUS IMMUNIZATION WITH HEPATITIS B VACCINE. I have previously completed a three-dose series of the Hepatitis B Vaccine. I understand that it is currently believed to be effective for life. I further understand that I will be contacted by UTSA's Occupational Health Coordinator if new information becomes available contradicting this belief.

Employee Signature: _____ Date: _____

☐ **C** I DECLINE taking the Hepatitis B vaccine.

DECLINATION STATEMENT. I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine, at no charge to me; however, I decline Hepatitis B vaccination at this time. I understand that by declining this vaccine I continue to be at risk of acquiring Hepatitis B, a serious disease. If, in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series at no charge to me.

Employee Signature: _____ Date: _____

UTSA OCCUPATIONAL HEALTH PROGRAM HEALTH ASSESSMENT

 Last Name First Name Middle Name Birth Date

 Department Supervisor / PI Job Title

I understand that the Health Assessment is **OPTIONAL** and provides a baseline health assessment that can assist the Occupational Health Program in offering targeted health risk counseling and/or referral to me. I also understand that I may be contacted by the Occupational Health Program medical staff to clarify my response, or lack of response, to certain questions asked in this section.

_____ By initialing here, I understand the information as stated above _____ I DECLINE participation in the OHP Health Assessment
 Initial Here Initial Here

 Emergency Contact last name Emergency Contact first name Emergency contact phone number

Emergency Contact relationship

 Name of your personal physician Personal physician phone number

Relevant Health and Vaccination History

		Please provide additional information including dates to all yes answers
1. Do you have a prior injury or illness related to animal contact or biomedical research?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Have you ever been diagnosed with asthma?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Have you ever been diagnosed with allergies?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Have you ever tested positive for tuberculosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
5. Have you ever failed a pulmonary function test?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6. Have you ever had blood tests with abnormal results?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7. Have you had any X-rays, CT scans, or MRI with abnormal results in the last two years?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
8. Are you aware of any existing medical conditions that might create an animal or chemical contact risk that has not been addressed elsewhere, please list here?		
9. Are you aware of any existing medical conditions that might compromise your ability to safely wear a respirator?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Return forms via campus mail to Occupational Health Coordinator or Fax to 5072.

Health Assessment UTSA OCCUPATIONAL HEALTH PROGRAM

Individual Health Information

YES	NO	GENERAL	OTHER PROBLEMS OR COMMENTS TO YES RESPONSES
<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Changes	
<input type="checkbox"/>	<input type="checkbox"/>	Fever or Sweats	
<input type="checkbox"/>	<input type="checkbox"/>	Fatigue	
		SKIN	OTHER PROBLEMS OR COMMENTS TO YES RESPONSES
<input type="checkbox"/>	<input type="checkbox"/>	Rashes or Hives	
<input type="checkbox"/>	<input type="checkbox"/>	Eczema	
<input type="checkbox"/>	<input type="checkbox"/>	Bruising	
		HEAD	OTHER PROBLEMS OR COMMENTS TO YES RESPONSES
<input type="checkbox"/>	<input type="checkbox"/>	Blackout Spells/Fainting	
<input type="checkbox"/>	<input type="checkbox"/>	Head Injury/Loss of Consciousness	
<input type="checkbox"/>	<input type="checkbox"/>	Headaches	
<input type="checkbox"/>	<input type="checkbox"/>	Seizures	
		EYES	OTHER PROBLEMS OR COMMENTS TO YES RESPONSES
<input type="checkbox"/>	<input type="checkbox"/>	Trouble Seeing	
<input type="checkbox"/>	<input type="checkbox"/>	Redness	
<input type="checkbox"/>	<input type="checkbox"/>	Itching	
<input type="checkbox"/>	<input type="checkbox"/>	Glasses or Contacts	
<input type="checkbox"/>	<input type="checkbox"/>	Color Blind	
<input type="checkbox"/>	<input type="checkbox"/>	Watering Eyes	
		EARS	
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Hearing	
<input type="checkbox"/>	<input type="checkbox"/>	Infection	
<input type="checkbox"/>	<input type="checkbox"/>	ringing	
<input type="checkbox"/>	<input type="checkbox"/>	Hearing Aid	
		NOSE, SINUSES, THROAT, MOUTH	OTHER PROBLEMS OR COMMENTS TO YES RESPONSES
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Infections/Colds	
<input type="checkbox"/>	<input type="checkbox"/>	Breathing Problems	
<input type="checkbox"/>	<input type="checkbox"/>	Trouble Smelling Odors	
<input type="checkbox"/>	<input type="checkbox"/>	Sore Throat/Hoarseness	
<input type="checkbox"/>	<input type="checkbox"/>	Nasal Congestion/Runny Nose	
		RESPIRATORY	OTHER PROBLEMS OR COMMENTS TO YES RESPONSES
<input type="checkbox"/>	<input type="checkbox"/>	Cough (Dry or with Phlegm or Blood)	
<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	
<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	
<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Chest X-ray	
		CARDIAC	OTHER PROBLEMS OR COMMENTS TO YES RESPONSES
<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	
<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	
<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	
<input type="checkbox"/>	<input type="checkbox"/>	Valvular Heart Disease or Murmur	
<input type="checkbox"/>	<input type="checkbox"/>	Palpitations	
		REPRODUCTIVE	OTHER PROBLEMS OR COMMENTS TO YES RESPONSES
<input type="checkbox"/>	<input type="checkbox"/>	Reproductive Health Concerns	
		GASTROINTESTINAL	OTHER PROBLEMS OR COMMENTS TO YES RESPONSES
<input type="checkbox"/>	<input type="checkbox"/>	Trouble swallowing	
<input type="checkbox"/>	<input type="checkbox"/>	Vomiting, Heartburn or Indigestion	
<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding from the Mouth or bowel	
<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease or Hepatitis	
<input type="checkbox"/>	<input type="checkbox"/>	Hernia	
		URINARY	
<input type="checkbox"/>	<input type="checkbox"/>	Pain with Urination or Blood in Urine	OTHER PROBLEMS OR COMMENTS TO YES RESPONSES
<input type="checkbox"/>	<input type="checkbox"/>	Change in Urinary Habits	

Return forms via campus mail to Occupational Health Coordinator or Fax to 5072.

REV 8/2020

**Health Assessment
UTSA OCCUPATIONAL HEALTH PROGRAM**

<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	
YES	NO	MUSCULOSKELETAL	OTHER PROBLEMS OR COMMENTS TO YES RESPONSES
<input type="checkbox"/>	<input type="checkbox"/>	Back Pain	
<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain or Stiffness	
<input type="checkbox"/>	<input type="checkbox"/>	Limitation of Motion	
<input type="checkbox"/>	<input type="checkbox"/>	Weakness	
		EXTREMITIES	OTHER PROBLEMS OR COMMENTS TO YES RESPONSES
<input type="checkbox"/>	<input type="checkbox"/>	Numbness	
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Walking	
<input type="checkbox"/>	<input type="checkbox"/>	Swollen Ankles or Feet	
		ENDOCRINE	OTHER PROBLEMS OR COMMENTS TO YES RESPONSES
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	
<input type="checkbox"/>	<input type="checkbox"/>	Type/Insulin(s)/Oral Med(s)	
		IMMUNE	OTHER PROBLEMS OR COMMENTS TO YES RESPONSES
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	
<input type="checkbox"/>	<input type="checkbox"/>	Immunosuppression	
<input type="checkbox"/>	<input type="checkbox"/>	Tumor	

HOSPITALIZATIONS – List any hospitalizations during the past five years:

SURGURIES - list surgeries (with approximate dates) that you have had:

INJURIES – Have you ever been treated for low back pain? If so, please list details:

MEDICATIONS – Please list any prescription or over-the-counter drugs, including supplements, you take and the reason for taking them:

OUTSIDE EMPLOYMENT/HOBBIES – What outside hobbies or employment do you have that would predispose you to risk or injury with your work duties at UTSA:

I have answered this form truthfully and to the best of my recollection.

Signature

Date