CLEMSON UNIVERSITY, MEDICAL SURVEILLANCE PROGRAM
Occupational Profile/Health History/Consent

NAME _____ _____ _____
LAST FIRST MIDDLE

DATE OF BIRTH __/__/____; Clemson University ID #: _____

(Circle appropriate responses): Male Female

Single Married Separated Divorced Widowed Other: _____

Asian Black Hispanic White Other: _____

For Faculty/Staff:

Department: _____

Supervisor's name: _____

For Students:

Department: _____

Faculty (teacher/supervisor): _____
__ Undergraduate
__ Graduate

Permanent mailing address: _____

Best contact number # (_____)_____ Email address _____

Combined MSP Acknowledgement and Consent Form

I understand that as part of my Medical Surveillance healthcare, the Joseph F. Sullivan Center originates and maintains health records describing my health history, symptoms, examination, test results, diagnoses, treatment, etc. I consent to treatment by the Medical Surveillance Program at JFSC, including office visits, laboratory testing, office procedures, or other treatment directly related to care. I understand the Center is an academic nursing center that supports the mission (teaching, research, and service) of Clemson University. I understand that students, supervised by faculty professionals, are an integral part of operations.

Signature _____ Date _____

Print Name: _____ DOB ____ / ____ / _____

CLEMSON UNIVERSITY, MEDICAL SURVEILLANCE PROGRAM
Occupational Profile/Health History/Consent

List all possibly hazardous exposures in your job/ research:

Animals: ☐ Aquatic ☐ Birds ☐ Farm ☐ Insect ☐ Lab ☐ Wild
Animal populations: _____
Human/primate: ☐ Blood ☐ Blood product
Environmental: ☐ Chemicals ☐ Dust ☐ Noise
☐ Other _____

☐ Yes ☐ No I will be exposed to animal populations that may carry rabies.
☐ Yes ☐ No I will be involved in **recombinant DNA technology, Human Gene Transfer,** or **Xenotransplantation**?
☐ Yes ☐ No (**For women only**): I am pregnant, or planning to be pregnant in the near future?

Medical History: ☐ I have no significant medical history

Current Medications: (List all) _____ ☐ None

☐ Anemia
☐ Arthritis
☐ Cancer
☐ Diabetes
☐ Difficulty Smelling
☐ Dizziness or Fainting
☐ Hearing Problems
☐ Heart Problems
☐ Heat Stroke
☐ High Blood Pressure
☐ Joint or Muscle Problems
☐ Kidney or Liver Disease
☐ Rheumatic / Scarlet Fever
☐ Seizures / Epilepsy
☐ Stomach / Bowel Problems
☐ Tuberculosis
☐ Vision Problems
☐ Other: _____

☐ Yes ☐ No I have a *medical condition* or *take medications/treatments* that impair your immune system (such as HIV, cortisone, chemotherapy, radiation, etc.)?
☐ Yes ☐ No I have a pre-existing cardiac valvular disease or have a vascular graft?

Allergy History:

Do you have or have you had any of the following diseases or conditions?

		When?	Explanation
☐ Yes ☐ No	Asthma/Wheezing	_____	_____
☐ Yes ☐ No	Chronic Cough/ Bronchitis	_____	_____
☐ Yes ☐ No	Eczema/Skin rash	_____	_____
☐ Yes ☐ No	Hay Fever/Seasonal allergies	_____	_____
☐ Yes ☐ No	Itchy, irritated eyes	_____	_____
☐ Yes ☐ No	Shortness of breath	_____	_____
☐ Yes ☐ No	Other lung/breathing problems	_____	_____

☐ Yes ☐ No Allergies to foods or medicines: (list) _____
☐ Yes ☐ No Allergies to pollen, grass, weeds, trees, yeast or molds: (list) _____
☐ Yes ☐ No Allergies to latex, chemicals, or other substances: (list) _____
☐ Yes ☐ No Allergies to animals: (list) _____

Immunization/ TB test history **(can be listed as Month/Day/Year; Month/Year; or Year):**

Tetanus: Td _____ **or** Tdap _____;
Hepatitis B _____ (date of series of completion): *If risk of exposure to human blood/blood product*.
Rabies: _____ (if applicable)

By signing this document, I certify that the health information provided is complete and accurate to the best of my knowledge.

Signature _____ Date _____

Print Name: _____ DOB ___ / ___ / _____

Name _____
DOB _____ Chart #_____