Instructions for Travel Clinic

For a safe and healthy trip, please make your appointment early, at least 4 - 6 weeks before you expect to travel. We will provide a customized up-to-date health and immunization plan for the country(s) to which you will travel. Please expect at least (2) visits for Travel Medicine. You will be scheduled initially with a nurse for travel vaccines, then with a provider (to review vaccines, travel location, basic travel information, to provide necessary prescriptions). You maybe able to make both appointments on Tuesday or Thursday mornings. We need your assistance in the following ways:

1. Complete the Travel Medicine Consult Questionnaire before your appointment.

2. Pay the $13 travel consult fee after your visit.

3. **Bring all your immunization records to your appointment. If you have an International Vaccine Certificate, bring it with you.**

4. If you require immunizations, the follow fees* apply (depending upon which immunizations are needed):

   a. Hepatitis A \( \$7 \) per dose (2 doses/series)
   b. Hepatitis B \( \$15 \) per dose (3 doses/series)
   c. Influenza \( \$6 \)
   d. Menactra (meningitis) \( \$37 \)
   e. MMR \( \$19 \)
   f. Polio \( \$16 \)
   g. Tetanus/diphtheria (Td) \( \$7 \) (one injection/10 years)
   h. Tdap (tetanus/diphtheria/aceullar pertussis) \( \$11 \)
   i. Typhoid (Typhim/injection) \( \$19 \)
   j. Typhoid (Vivotif/oral) Prescription fee varies
   k. Varicella \( \$35 \) (per dose; 2 doses/series)

Fees are subject to change without notice.
4/24/2015
TRAVEL MEDICAL CONSULT QUESTIONNAIRE

Name:____________________________ Phone:____________________________
Date:____________________________
Student ID #:_____________________ Age:___________________________

Medical History: Please Circle “Yes” or “No” to the following questions:
1. Have you ever had reactions to immunizations/travel vaccines? Yes or No
2. Do you have any allergies to the following items? (Check all that apply)
   - Eggs
   - Neomycin
   - Antibiotics
   - Mercury (thimerosal)
   - Streptomycin
   - Polymyxin B
   - Vaccines
   - Bee Stings
3. Are there any other drugs to which you have had an allergic reaction? (Please list)
4. Are you being treated for leukemia, lymphoma, cancer or any other malignant diseases? Yes or No
5. Do you have or live with someone with a history of immune system deficiency? Yes or No
6. Do you have a history of anemia or any other blood disorder? Yes or No
7. Do you have G6PD deficiency? Yes or No
8. Do you have any existing medical conditions such as diabetes, heart disease or pulmonary disease? (If Yes, please list)
9. Do you have any history of kidney disease? Yes or No
10. Do you have any history of psychiatric disorder? Yes or No
11. Do you have history of seizures? Yes or No
12. List all the medications you are taking:_________________________________________________________________

Reasons for travel: Education Pleasure Research Service (i.e, medical)

WOMEN ONLY
13. Are you pregnant, suspect you may be pregnant or trying to become pregnant? Yes or No
14. Are you breast-feeding? Yes or No

TRAVEL INFORMATION: Departure Date:_____________ Return Date:_____________
15. Please indicate; in order of travel the countries and cities you are traveling to:
   Destination (City/Country) Where will you stay? Length of Stay? Rural Travel or Camping?
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

Please list any side or day trips planned:
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

Will you be traveling above 8,000 feet? Yes or No   Do you plan to scuba dive? Yes or No

16. Please check all the travel vaccines you have had and the dates given:
   Hepatitis A______ Flu Vaccine______ Plague______ Pneumococcal Vaccine______
   Hepatitis B______ Immune Globulin______ Malaria drug______ Polio-Oral or Injectable?
   Measles_______ Tetanus/Diphtheria______ Typhoid______
   Japanese Encephalitis
   Mumps_______ Tuberculin (TB)______ Cholera______ Rubella_______
   Rabies_______ Meningococcal_______

PLEASE BRING YOUR IMMUNIZATION RECORD TO YOUR APPOINTMENT!

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