

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 to the country(s) you will be traveling to. Please expect at least (2) visits for Travel Medicine. You will be scheduled initially with a provider (to review vaccines, travel location, basic travel information, to provide necessary prescriptions), then a nurse for travel vaccines. You maybe able to make both appointments on Thursday or Friday mornings. We need your assistance in the following ways:

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

2. Pay the cashier \$25 after your visit.

- 3. Bring all your immunizations records to your appointment, also if you have an International Vaccine Certificate.**

4. If you require immunizations, the following charges will apply (depending upon which is needed; prices are subject to change):

- a. Hepatitis A \$21 per dose (2 doses/series)
- b. Hepatitis B \$28 per dose (3 doses/series)
- c. Influenza \$15
- d. Menactra (meningitis) \$94
- e. MMR \$54
- f. Polio \$22
- g. Tetanus/diphtheria (Td) \$20 (one injection/10 years)
- h. Tdap (tetanus/diphtheria/acellular pertussis) \$36
- i. Typhoid (Typhim/injection) \$42
- j. Typhoid (Vivotif/oral) prescription \$37
- k. Yellow Fever \$70

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 disease? 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 condition 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 a 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 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:
- | <u>Destination (City/ Country)</u> | <u>Where will you stay?</u> | <u>Length of Stay</u> | <u>Rural Travel or Camping?</u> |
|------------------------------------|-----------------------------|-----------------------|---|
| _____ | _____ | _____ | <input type="checkbox"/> Yes or <input type="checkbox"/> No |
| _____ | _____ | _____ | <input type="checkbox"/> Yes or <input type="checkbox"/> No |
| _____ | _____ | _____ | <input type="checkbox"/> Yes or <input type="checkbox"/> No |
| _____ | _____ | _____ | <input type="checkbox"/> Yes or <input type="checkbox"/> No |

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:
- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Hepatitis A _____ | <input type="checkbox"/> Flu Vaccine _____ | <input type="checkbox"/> Plague _____ | <input type="checkbox"/> Pneumococcal Vaccine _____ |
| <input type="checkbox"/> Hepatitis B _____ | <input type="checkbox"/> Immune Globulin _____ | <input type="checkbox"/> Malaria drug _____ | <input type="checkbox"/> Polio-Oral or Injectable? _____ |
| <input type="checkbox"/> Measles _____ | <input type="checkbox"/> Tetanus/Diphtheria _____ | <input type="checkbox"/> Typhoid _____ | <input type="checkbox"/> Japanese Encephalitis _____ |
| <input type="checkbox"/> Mumps _____ | <input type="checkbox"/> Tuberculin (TB) _____ | <input type="checkbox"/> Cholera _____ | <input type="checkbox"/> Yellow Fever _____ |
| <input type="checkbox"/> Rubella _____ | <input type="checkbox"/> Rabies _____ | <input type="checkbox"/> Meningococcal _____ | |

PLEASE BRING YOUR IMMUNIZATION RECORDS TO YOUR APPOINTMENT!