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 subscribe to a service that will provide a customized up-to-date health and immunization plan to the country(s) you will be traveling to. Please expect at least (2-3) visits for Travel Medicine. You maybe scheduled initially with a nurse (to review vaccines, travel location, basic travel information), then a provider, and lastly with a nurse for travel vaccines. We need your assistance in the following ways:

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

2. Pay the cashier $25.

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 $20 per dose (2 doses/series)
   b. Hepatitis B $26 per dose (3 doses/series)
   c. Influenza $15
   d. Menactra (meningitis) $94
   e. MMR $45
   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 will be given
   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 (thimerosol)
   - 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:

<table>
<thead>
<tr>
<th>Destination (City/ Country)</th>
<th>Where will you stay?</th>
<th>Length ofStay</th>
<th>Rural Travel or Camping?</th>
<th>Yes</th>
<th>No</th>
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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 ________
- □ Yellow Fever ________
- □ Rubella ________
- □ Rabies ________
- □ Meningococcal ________

**PLEASE BRING YOUR IMMUNIZATION RECORDS TO YOUR APPOINTMENT!**

pal 1/08