Date	Print Name (Last, First)	Student ID Number	DOB

Address **Contact Phone #**

ITINERARY

Date of Departure:_____Return Date: _____

Please indicate, in the order you will visit them, the countries you are traveling to. Also indicate length of stay in each country.

Destination (City, Country)	where will you stay?	Length of stay

Please circle all that apply to your travel plans:

Major Resort Hotels Cruise Ships Camping Rural Travel Staying With a Family Small Hotels
Safari Outdoor Activities Rented Foreign Home Youth Hostel OTHER:_____

What is the purpose of travel? (Please Circle)

Business Student Vacation Missionary Teacher Volunteer Agency
Field Work Climbing Diving OTHER:_____

Please circle all the vaccines you have had:

Cholera	Immune Globulin	Mumps	Rabies	Typhoid (Oral or injectable)
Diphtheria	Japanese Encephalitis	Pertussis	Rubella	Varicella
Flu Vaccine	Malaria Drugs	Plague	Smallpox	Yellow Fever
Hepatitis A	Measles	Pneumococcal	Tetanus	
Hepatitis B	Meningococcal	Polio (Oral or Injectable)	Tuberculin Test	

Do you have a current Travel Immunization Record? Yes No

IMMUNIZATIONS

	YES	NO
Have you ever fainted from having your blood drawn or from an injection?	☐	☐
Have you had a fever reaction to a vaccination?	☐	☐
Have you ever had any bad reaction or side effect from any vaccination?	☐	☐
Have you ever had Hepatitis A or B vaccine?	☐	☐
Do you live (or work closely) with anyone who has AIDS, an AIDS-like condition, any other immune disorder, or who is on chemotherapy for cancer?	☐	☐
Do you have a family history of immunodeficiency?	☐	☐
Have you received any injection of immune globulin or any blood product during the past 12 months?	☐	☐

Date	Print Name (Last, First)	Student ID Number	DOB

GENERAL MEDICINE	YES	NO
Do you have a medical condition that warrants maintenance medications or physician follow-up?	☐	☐
Do you have a medical condition that is stable now, but that may recur while traveling?	☐	☐
Have you had an acute illness or a fever in the past 48 hours?	☐	☐
Do you have asplenia?	☐	☐
Do you have HIV, AIDS, an AIDS-like condition, immune deficiency or other immune disorder, leukemia, or cancer, or are you taking immunomodulatory drugs or are you post-transplant?	☐	☐
Do you have severe combined immunodeficiency disease?	☐	☐
Do you have a history of problems with your thymus, such as Myasthenia Gravis, DiGeorge syndrome, or thymoma?	☐	☐
Do you have severe thrombocytopenia (low platelet count) or a coagulation disorder?	☐	☐
Have you ever had a convulsion, seizure, epilepsy, neurologic condition, or brain infection?	☐	☐
Do you have any stomach conditions?	☐	☐
Do you have a G6PD deficiency?	☐	☐
Do you have severe renal impairment?	☐	☐
Do you have bowel conditions such as diarrhea or constipation?	☐	☐
Do you have congenital malformation of the GI tract or chronic GI disorder?	☐	☐
Have you ever had hepatitis or yellow jaundice?	☐	☐
Do you have a history of psychiatric problems?	☐	☐
Do you have a problem with strange dreams and/or nightmares?	☐	☐
Do you have insomnia?	☐	☐
Do you have psoriasis?	☐	☐
Have you or a member of your household ever been diagnosed with eczema or atopic dermatitis?	☐	☐
Cardiac disease, with or without symptoms?	☐	☐
Do you have any eye conditions?	☐	☐
Are you prone to motion sickness?	☐	☐
Do you have asthma or wheezing?	☐	☐
Do you have multiple sclerosis?	☐	☐

Date	Print Name (Last, First)	Student ID Number	DOB

MEDICATIONS
ARE YOU TAKING OR WILL YOU BE TAKING THE FOLLOWING:

	YES	NO
Quinine, quinidine or medications for a cardiac conduction defect?	☐	☐
Chloroquine, Mefloquine, or Proguanil to prevent malaria?	☐	☐
Proguanil to prevent malaria?	☐	☐
Steroids, prednisone, cortisone or anti-cancer drugs?	☐	☐
Antibiotics or sulfonamides?	☐	☐
Ketoconazole?	☐	☐
Pepto-Bismol to prevent travelers' diarrhea?	☐	☐
Antacids?	☐	☐
Aspirin therapy (children and adolescents)?	☐	☐
Medications for emotional problems?	☐	☐
Medications for convulsions?	☐	☐

ALLERGIES
ARE YOU ALLERGIC OR HYPERSENSITIVE TO THE FOLLOWING:

	YES	NO
Any medications?	☐	☐
Amphotericin B?	☐	☐
Penicillin or Sulfa?	☐	☐
Mercury or Thimerosal?	☐	☐
Streptomycin?	☐	☐
Gentamicin?	☐	☐
Neomycin?	☐	☐
Polymyxin?	☐	☐
Kanamycin?	☐	☐
Sulfites?	☐	☐
Sodium metabisulfite	☐	☐
Protamine sulfate?	☐	☐
Aluminum or aluminum hydroxide?	☐	☐
Benzethonium chloride?	☐	☐
2-phenoxyethanol?	☐	☐

Yeast?	☐	☐
Eggs, egg protein, ovalbumin, or chicken protein?	☐	☐
Chlortetracycline?	☐	☐
Latex?	☐	☐
Gelatin?	☐	☐
Soy?	☐	☐
Lactose?	☐	☐
Bovine/calf/fetal serum albumin, protein, or extract?	☐	☐
Formaldehyde or formalin?	☐	☐

*Note: A "problem" listed above may be a contraindication or merely a precaution or merely an issue that warrants further discussion between the health care provider and patient to discuss risks/benefits of vaccination with that particular vaccine. The above "problem" list presents some common issues that arise in a pre-travel consultation but is not all-inclusive. Likewise, the list of allergies, hypersensitivities, and vaccine excipients is not comprehensive: providers should always check package inserts carefully. See CDC's Epidemiology and Prevention of Vaccine – Preventable Diseases (the "Pink Book") and Appendix B for a complete list of vaccine excipients.

COMMENTS:

_____
_____
_____
_____
_____

SIGNATURE OF TRAVELER:_____ DATE:_____

SIGNATURE OF HEALTH CARE PROVIDER:_____ DATE:_____

The information in this questionnaire is not a substitute for medical advice from a health care provider on an individual basis.

STUDENT HEALTH SERVICES FINANCIAL INFORMATION FORM

Typically there are charges for your travel service visit and for any immunizations.

1. Is a Morehouse College /department responsible for paying the charges?

   _____Yes _____No

If yes, complete the following:

Name of Departmental Contact Person: _____

College/Department: _____

Building Address for Contact Person:_____

Phone Number for Contact Person: _____

2. If the answer to Question 1 is No, the charges can be paid at the Bursar's Office on the 2nd floor of Gloster Hall.

_____

Patient's Name (PRINT)

_____ _____

Patient's Signature Date

_____

MC ID #

Distribution:
Financial
Services
Student Health Center Fund 100 Org. 459