

Today’s Date:

# Travel Clinic Information

Departure Date:

Name: MUID:

Return Date:

Previous travel to:

Previous Malaria medication:

# Itinerary

Side Effects:

List all countries, cities, and areas you will visit in order of travel. Please attach additional sheet if needed.

|  |  |  |  |
| --- | --- | --- | --- |
| Country | Length of stay | Major City/Cities | Rural Areas# of days if malaria is concern |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Primary purpose of trip: Study Abroad Tourism Healthcare work Volunteer Work

Plans include: Scuba diving High altitude (>8000ft/2500m.) Ship Travel Other Lodging: Resort/Hotel House Tent Other

Are you currently enrolled in a health insurance plan that covers while overseas? YES NO Do you have medical evacuation insurance? YES NO

Medical Problems (circle past or present): NONE

|  |  |  |  |
| --- | --- | --- | --- |
| Heart disease/Abnormal Rhythm | Lung Disease | Kidney Disease | Liver Disease |
| Gastrointestinal Disease | Retina Disease (Eye) | Spleen Removed | Psoriasis |
| Seizures/Epilepsy Clotting/Bleeding Disorder | Psychiatric Illness G6PD Deficiency | Neurologic Disorder | Myasthenia Gravis |

Do you have any medical conditions that warrant maintenance medications or physician follow-ups? YES NO Current Medications (including OTC, contraceptives, supplements) :

Allergies: Medications

Foods

Insects/Beesting

Vaccines

Type of reaction:

## Marquette University logoPatient Name: MUID:

Screening Questionnaire for Adult Immunization

1. Do you have documentation of having your routine childhood vaccination series? YES NO
2. Have you ever had a serious reaction to receiving a vaccine? YES NO
3. Do you have cancer, leukemia, AIDS, or any other immune system problems? YES NO
4. Do you take cortisone, prednisone, steroids, or anticancer drugs or have you had x-ray treatments? YES NO
5. Have you had a seizure or other nervous system problem? YES NO
6. During the last year have you received a transfusion of blood or blood products or been given a medicine called immune (gamma) gloubin? YES NO
7. For Women: Are you pregnant, breastfeeding or is there a chance you could become pregnant during the month following vaccination? YES NO
8. Have you received any vaccination in the last 4 weeks? YES NO
9. Have you ever fainted from having your blood drawn or from an injection? YES NO

Immunization History

|  |  |
| --- | --- |
| Immunizations | Dates of Immunizations |
| Tetanus, TD, DPT, TdapLast booster dose | 1.  |
| Polio by injection or oral | 1. 2. 3. 4.  |
| MMR | 1. 2.  |
| Chicken Pox or Varicella(give dates of disease or vaccine) | 1. 2. Date of disease:  |
| Hepatitis A | 1. 2.  |
| Hepatitis B series | 1. 2. 3.  |
| Meningitis | Menactra Menomune  |
| Typhoid | Injection Oral  |
| Yellow Fever | 1.  |
| Rabies series | 1. 2. 3. (pre-exposure) |
| Influenza | 1.  |
| Japanese Encephalitis | 1. 2.  |
| TB Test | Date: Results:  |

## I attest that the above information is true to the best of my knowledge.

(Student signature)

SKO 5/2013