



Southwest Utah Public Health Department

International Travel Intake Form All information is strictly confidential

Today's Date: _____

Patient Last Name		First Name		MI	Date of Birth (mm/dd/yyyy)		Age
Race <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> American Indian <input type="checkbox"/> Alaskan Native <input type="checkbox"/> Pacific Islander			Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Non Hispanic		Language		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Address					City	State	Zip code
Primary Phone #		Best Form of Contact <input type="checkbox"/> Phone Call <input type="checkbox"/> Text <input type="checkbox"/> Email		Email:			
Primary Health Insurance			Policy ID#		Policy Holder (exact name listed on card)		
Insurance Policy Holder Date of Birth (mm/dd/yy)			Relationship to Patient		Address of Policy Holder		
<p>I certify that the information I have provided is true and accurate. I have been given a copy and have read, or have had explained to me, the information contained in the important Vaccine Information Statements. I have had a chance to ask questions, which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccines and request that the vaccines indicated be given to the person named above for whom I am authorized to make this request. I agree that this information may be shared with schools, day care centers, health care providers and others when deemed medically necessary. I HEREBY RELEASE SOUTHWEST UTAH PUBLIC HEALTH DEPARTMENT, AND ITS EMPLOYEES, FROM ALL CLAIMS ARISING FROM SUCH IMMUNIZATIONS.</p> <p>I UNDERSTAND THE BILLING OF MEDICAL INSURANCE DOES NOT GUARANTEE PAYMENT AND THAT I AM RESPONSIBLE FOR ANY UNPAID BALANCE.</p> <p>We are required to inform you of our privacy practices for the information we collect and keep about you. I have been given a copy of the Health Department's Notice of Privacy Practices and have had an opportunity to ask questions about how my information may be used.</p>							
Full Name: _____		Signature: _____			Date: _____		
Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Other							

SECTION 1: TRAVEL INFORMATION

Departure Date: _____ Return Date: _____ Total Length of Trip: _____
 Number of people traveling with you: _____ Or number in your tour group: _____

ITINERARY: Please list your itinerary in order and include the length of time you will be staying at each location including airport stops and any layovers.

<u>Country</u>	<u>City/Area</u>	<u>Duration</u>	<u>Country</u>	<u>City/Area</u>	<u>Duration</u>
<input type="checkbox"/> See attached itinerary			4. _____	_____	_____
1. _____	_____	_____	5. _____	_____	_____
2. _____	_____	_____	6. _____	_____	_____
3. _____	_____	_____	7. _____	_____	_____

PURPOSE OF TRIP: Check all that apply

- Business/work Receive medical care Provide medical care Visit family/friends
 Adoption Vacation Non-LDS mission/humanitarian Other: _____

**LDS mission name & MTC location

****LDS Mission Skip to Section 3: Medical History**

NAME: _____ Date: _____

SECTION 2: ADDITIONAL TRAVEL

TYPE OF TRAVEL: Check all that apply

- Guided/escorted tour
- Independent travel
- Rural areas
- Urban/major cities
- Fixed itinerary
- Flexible itinerary
- Usual tourist areas
- Unusual tourist areas

PLANNED ACCOMMODATIONS:

- Hotel: 3-5 star
- Local apartment
- Dorm style lodging
- Live with locals/private home
- Cruise ship
- Remote location
- Camping
- Hostels
- Other: _____

ACTIVITIES: Check all that apply

- Tour bus
- Automobile travel
- Motorcycle/bicycle
- Cruise ship travel
- Ocean/salt water
- Scuba diving
- Fresh water; rivers/lakes
- Rafting/kayaking
- Altitude above 8,000 ft (2500 m)
- Sun exposure
- Caving (spelunking)
- Camping/hiking
- Animal contact/hunting
- Field work
- Safari
- _____

CHECK ANY ITEMS YOU WOULD LIKE TO DISCUSS:

- Altitude sickness
- Insect borne diseases
- Air travel/jet lag
- Risk of malaria
- Travelers' diarrhea
- Medical care/evacuation insurance
- Food & water safety
- Motion sickness
- Other: _____
- Seeking medical care
- Risk of blood borne infections

SECTION 3: MEDICAL HISTORY

PERSONAL MEDICAL INFORMATION	Yes	No
Are you sick today (with moderate to severe fever or acute illness)?		
Have you previously traveled to any developing country?		
Did you receive your childhood vaccines?		
Have you ever had chickenpox disease or the vaccine series? If yes, which one: _____		
Are you currently under a physician's care for any health problem?		
Do you smoke?		
Do you have a personal history or family history of Guillain-Barré Syndrome (GBS)?		
Have you taken cortisone, prednisone, other steroids, anti-cancer drugs, or had radiation in the last 3 months?		
Do you have any seizure or brain problems?		
Have you received gamma-globulin or blood transfusions within the past year?		
Have you received any vaccinations or a TB test in the past 4 weeks?		
Have you ever taken anti-malarial medication? If yes, what medication: _____ Did you tolerate it? ____		
Are you, or will you be, at risk for blood borne infections such as HIV, AIDS, or Hepatitis B and C?		
(Females) Are you pregnant or planning on pregnancy? If yes, when: _____		
(Females) Are you currently breastfeeding? If yes, how old is the infant: _____		

MEDICAL HISTORY

- NONE**
- Thrombophlebitis/blood clots
- Recurrent pneumonia
- Kidney disease
- Heart arrhythmia/ablation
- Conditions treated w/immunosuppressive medications: cancer, leukemia, lymphoma, organ transplant, rheumatoid arthritis, Crohn's, ulcerative colitis
- Hepatitis/liver disorders
- Mental/emotional illness
- Prostate problems
- Blood thinning meds
- Recent surgeries
- Seizures/epilepsy
- Diabetes
- HIV or AIDS
- Psoriasis
- Thymus dysfunction (including myasthenia gravis, thymoma, thymectomy)
- Heart disease/attacks
- Retinal or visual field changes
- Splenectomy
- Stomach or bowel conditions

ALLERGIES	Yes	No
Have you ever had a serious or life-threatening allergic reaction?		
Are you allergic to any of the following? <input type="checkbox"/> Sulfa <input type="checkbox"/> Neomycin <input type="checkbox"/> Streptomycin <input type="checkbox"/> Polymyxin B <input type="checkbox"/> Eggs or chicken protein <input type="checkbox"/> Baker's Yeast <input type="checkbox"/> Gelatin <input type="checkbox"/> Bee Stings		
Other Allergies: please list _____		

MEDICATION INFORMATION <input type="checkbox"/> NONE			
<i>(Include prescriptions, contraceptives, vitamins, antibiotics, herbal, and over-the-counter)</i>			
Medication	Reason for Taking	Medication	Reason for Taking