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	Ethnicity	Language	Gender
☐ White ☐ Black ☐ Asian ☐ American Indian ☐ Alaskan Native ☐ Pacific Islander	☐ Hispanic ☐ Non Hispanic		☐ Male ☐ Female

Address	City	State	Zip code

Primary Phone #	Best Form of Contact	Email:
	☐ Phone Call ☐ Text ☐ 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

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.

I UNDERSTAND THE BILLING OF MEDICAL INSURANCE DOES NOT GUARANTEE PAYMENT AND THAT I AM RESPONSIBLE FOR ANY UNPAID BALANCE.

We are required to inform you of our privacy practices for the information we collect and keep about you. I have been offered 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.

Full Name: _____Signature: _____ Date: _____

Relationship to Patient: ☐ **Self** ☐ **Parent** ☐ **Legal Guardian** ☐ **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.

Country	City/Area	Duration	Country	City/Area	Duration
☐ See attached itinerary					
1._____	_____	_____	4. _____	_____	_____
2._____	_____	_____	5. _____	_____	_____
3._____	_____	_____	6. _____	_____	_____
			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 ☐ Rural areas ☐ Fixed itinerary ☐ Usual tourist areas
☐ Independent travel ☐ Urban/major cities ☐ Flexible itinerary ☐ Unusual tourist areas

PLANNED ACCOMMODATIONS:

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

ACTIVITIES: Check all that apply

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

CHECK ANY ITEMS YOU WOULD LIKE TO DISCUSS:

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

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** ☐ Hepatitis/liver disorders ☐ Seizures/epilepsy ☐ Heart disease/attacks
☐ Thrombophlebitis/blood clots ☐ Mental/emotional illness ☐ Diabetes ☐ Retinal or visual field changes
☐ Recurrent pneumonia ☐ Prostate problems ☐ HIV or AIDS ☐ Splenectomy
☐ Kidney disease ☐ Blood thinning meds ☐ Psoriasis ☐ Stomach or bowel conditions
☐ Heart arrhythmia/ablation ☐ Recent surgeries ☐ Thymus dysfunction (including myasthenia gravis, thymoma, thymectomy)
☐ Conditions treated w/immunosuppressive medications: cancer, leukemia, lymphoma, organ transplant, rheumatoid arthritis, Crohn's, ulcerative colitis

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

MEDICATION INFORMATION ☐ **NONE**

(Include prescriptions, contraceptives, vitamins, antibiotics, herbal, and over-the-counter)

Medication	Reason for Taking	Medication	Reason for Taking