Southwest Utah Public Health Department

International Travel Intake Form

All information is strictly confidential

Appointment Date: _____

Patient Last Name	First Name	Middle	Date of Birth (mm/dd/yyyy)	Age	Gender ☐ Male ☐ Female

Race ☐ White ☐ Black ☐ Asian ☐ American Indian ☐ Alaskan Native ☐ Pacific Islander	Ethnicity ☐ Hispanic ☐ Non Hispanic	Emergency Contact (name, phone number, relationship)

Address	Unit/Apt	City	State	Zip code

Primary Phone #	☐ Cell ☐ Home ☐ Work	Best Form of Contact	☐ Phone Call ☐ Text ☐ Email	Email: Please contact me about upcoming events and services: ☐Opt-in ☐Opt-out

Primary Health Insurance	Policy #	Policy Holder (Exact name listed on Card)

Insurance Policy Holder Date of Birth (mm/dd/yyyy)	Relationship to Patient	Address of Policy Holder

→ Sign Here

I acknowledge that I am the (1) above Traveler and an adult or (2) parent or legal guardian of the above minor Traveler and have requested a Travel Consultation for the Traveler from Southwest Utah Public Health Department (SWUPHD), which is intended to provide general information relevant to the above travel plans to the identified country(ies). I understand and agree that: The Travel Consult (i) may not provide an exhaustive list of all risks associated with, or conditions to, the above travel plans; (ii) does not constitute medical advice and is not being conducted for diagnostic or treatment purposes. I have been offered a copy of SWUPHD privacy notice and have had the opportunity to ask questions to my satisfaction regarding the vaccinations and prescriptions I may receive today. I have been given a copy and have read, or have had explained to me, the information contained in the vaccine information sheets. 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 am aware this information may be shared when necessary for my medical care, operations, payment and upon my written consent. I am aware that vaccinations received will be entered into the Utah Statewide Immunization Information System (USIIS) unless I choose to opt out.
I HEREBY RELEASE SOUTHWEST UTAH PUBLIC HEALTH DEPARTMENT, AND ITS EMPLOYEES, FROM ALL CLAIMS ARISING FROM SUCH SERVICES. I UNDERSTAND THE BILLING OF MEDICAL INSURANCE DOES NOT GUARANTEE PAYMENT AND THAT I AM RESPONSIBLE FOR ANY UNPAID BALANCE.

X Signature _____ Print Name: _____ 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			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: _____ Appointment 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	Dosage	Reason for Taking	Medication	Dosage	Reason for Taking