STUDENT LIFE
UNIVERSITY HEALTH SERVICE
UNIVERSITY OF MICHIGAN

# Travel Health Services Form



## Instructions:

*Please **provide as much information as possible** so we can best serve you, and be sure to **submit your form promptly** so you can schedule your appointment.*

*Use free Adobe Reader to complete this form so you can type, save and print your form. Apple product users, **do NOT use Preview** because it causes problems, e.g. blank forms.*

***Email your completed form to UHS-forms@med.umich.edu** ("med" is required in this email address; email is not secure, may not be read every day, and should not be used for urgent or sensitive issues)*

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## About you:

Your name – Last: _____ First: _____ Date of Birth: _____

Are you traveling with a U-M group? _____ If yes, which one? _____

Best phone number: _____

## Itinerary: *List your primary destination(s), plus any travel before and after that location.*

| Destination -- country & location: | Arrival date: | Departure date: | Accommodations e.g. hotel, camp | Overnight in rural area? |
|---|---|---|---|---|
| USA, Ann Arbor | | | | |
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## Health information:

Current medications and supplements: _____

Allergies, medical and other: _____

Chronic medical conditions: _____

# Travel Health Services Form



Your name – Last: _____ First: _____ Date of Birth: _____

*This information will be used to determine which immunizations and medications you need and will receive at your clinic visit. If your program does not pay, you would be responsible for payment at time of service.*

## Your immunization history is (check all that apply):

☐ Marked below -- Who completed this information?
☐ Student ☐ Other (specify):_____

☐ Attached -- be sure to include patient's name and date of birth on any attachments

☐ Previously submitted to UHS -- note: UHS does not have access to immunizations records that you may have given to another U-M unit

☐ Other (specify):_____

**Diphtheria-Tetanus- Pertussis (DTaP):**
Primary series Dose 1: month_____ day_____ year_____
Dose 2: month_____ day_____ year_____
Dose 3: month_____ day_____ year_____
Dose 4: month_____ day_____ year_____
Dose 5: month_____ day_____ year_____
Booster: ☐ Td ☐ Tdap
month_____ day_____ year_____

**Hepatitis A:** Dose 1: month_____ day_____ year_____
Dose 2: month_____ day_____ year_____

**Hepatitis A+B Combination (TWINRIX):**
Dose 1: month_____ day_____ year_____
Dose 2: month_____ day_____ year_____
Dose 3: month_____ day_____ year_____

**Hepatitis B:** Dose 1: month_____ day_____ year_____
Dose 2: month_____ day_____ year_____
Dose 3: month_____ day_____ year_____

**Influenza:** month_____ day_____ year_____

**Japanese Encephalitis:**
Dose 1: month_____ day_____ year_____
Dose 2: month_____ day_____ year_____

**Meningitis (Meningococcal):**
Initial: month_____ day_____ year_____
Booster: month_____ day_____ year_____

**Measles, Mumps, Rubella (MMR):**
Dose 1: month_____ day_____ year_____
Dose 2: month_____ day_____ year_____

**Polio:**
Primary series Dose 1: month_____ day_____ year_____
Dose 2: month_____ day_____ year_____
Dose 3: month_____ day_____ year_____
Dose 4: month_____ day_____ year_____
Adult booster: month_____ day_____ year_____

**Rabies Pre-Exposure:**
Dose 1: month_____ day_____ year_____
Dose 2: month_____ day_____ year_____
Dose 3: month_____ day_____ year_____

**Typhoid:** ☐ Oral ☐ Intramuscular (shot)
month_____ day_____ year_____

**Varicella:** Had disease: month_____ day_____ year_____
Dose 1: month_____ day_____ year_____
Dose 2: month_____ day_____ year_____

**Yellow Fever**: month_____ day_____ year_____

**Tuberculosis Test:**
Result:_____ month_____ day_____ year_____

**Other** including positive titers (test for immunity):
_____ month_____ day_____ year_____
_____ month_____ day_____ year_____