Foreign Travel Vaccination Consultation Self-Screening Patient Intake Form

PATIENT INFORMATION

Date: _____/_____/_____ **Date of Birth :**_____/_____/_____**Age:**_____

Legal Name:_____ **Sex Assigned at Birth (circle):** M / F

Street Address: _____

Phone:_____ **Email Address:**_____

TRAVEL SPECIFICS

Purpose of Trip: _____

Activities: _____

Departure Date: _____Return Date: _____

Countries AND Cities to be Visited (In Order of Visits)	Arrival Date	Departure Date

Have you traveled outside the United States before? □ Yes □ No

If yes, where and when? _____

1.	Will you be ONLY using airplane as your mode of transportation If no, explain: _____	□ Yes □ No □ Not sure
2.	Will you be ONLY visiting major cities? If no, explain: _____	□ Yes □ No □ Not sure
3.	Will you be ONLY staying in hotels? If no, explain: _____	□ Yes □ No □ Not sure
4.	Will you be visiting friends and family?	□ Yes □ No □ Not sure
5.	Will you be ascending to high altitudes? (> 7,000 ft or 2,300 meters) in the mountains	□ Yes □ No □ Not sure
6.	Will you be working in the medical or dental field with exposure to blood or bodily fluids?	□ Yes □ No □ Not sure

QUESTIONS/CONCERNS

Please list additional questions or concerns that you might have regarding your travel:

_____

_____

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ALLERGIES & MEDICAL HISTORY

□ No known drug allergies □ No known food allergies

Drug Allergies: _____

Food Allergies: _____

List your current prescription medical conditions and medications (include birth control pills and anti-depressants):

Current Medical Conditions: _____

_____

Current Prescription Medications: _____

_____

Regularly used non-prescription medications (over the counter, herbal, homeopathic, vitamins, and supplements including those purchased at health-food stores): _____

1.	Are you currently using steroids?	□Yes □No □Not sure
2.	Are you currently receiving chemotherapy or radiation therapy?	□Yes □No □Not sure
3.	Do you have a suppressed immune system?	□Yes □No □Not sure
4.	Are you receiving immunosuppressive therapy?	□Yes □No □Not sure
5.	Are you pregnant, planning to become pregnant or currently breastfeeding?	□Yes □No □Not sure
6.	Do have a disorder or disease of the thymus such as myasthenia gravis or Di George Syndrome? Or have had your thymus removed or had heart surgery?	□Yes □No □Not sure

If your vaccination records are not available electronically, please list your vaccine history or attach a copy of your vaccination records when turning the self-screening form in: _____

_____

_____

_____

FOREIGN TRAVEL VACCINE CONSULTATION AND VACCINE FEES

Foreign Travel Vaccine Consultations are fee based and are not covered by insurance. The fees are per person and there is not a discount for groups or for two are more people being seen at the same time. Payment is expected at the time of the consultation.

Low Complexity: $79.00
Moderate Complexity: $140.00
High Complexity: $201.00

Please initial that you have read and understand that you are responsible for paying the Foreign Travel Vaccine Consultation fee at the time of the consultation visit: _____

There will be a separate cost for the vaccine(s) and for the administration of the vaccine(s). Many insurance companies do not cover the cost of foreign travel immunizations. You will be responsible for paying the administration and vaccine fees that cannot be billed or not covered by your health insurance. Payment is expected at the time of the consultation and vaccination appointment.

Please initial that you have read and understand that you are responsible for paying the administration and vaccine fees at the time of the consultation visit and vaccination appointment: _____

TRAVELER'S SIGNATURE

Name: _____ Date of Birth: _____

Signature: _____ Today's Date: _____

JACKSON COUNTY
Health & Human Services