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.*

To deliver your form:

- *Email 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) OR*
- *Deliver printed forms to UHS Allergy, Immunization and Travel Health Clinic, Mon-Fri (closed noon-1 PM)*

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				

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_____