TRAVEL HEALTH ASSESSMENT FORM

Legal Name ___________________________ Last __________ First ________ Middle Initial _______ Preferred Name ________________________________

Student PID Number __________ Date of Birth __________ Legal Sex _______ Preferred Pronouns (ie. he/him, she/her, they/their) _______

Preferred Mailing Address __________________________________________ Primary Contact Number __________________________ Primary E-mail __________________________

Travel Specifics

Purpose of Trip:

☐ School Related Study ☐ Pleasure ☐ Business ☐ Other: ______________________________________________________________

Does your program require the completion of a medical form/physical by a medical provider? ☐ Yes ☐ No

What will you be doing on this trip? ___________________________________________________________________________________________

Are you traveling alone, with family/friends, in a group? _____________________________________________________________________________

Departure Date from United States: ______________ Return Date to United States: __________________________

List your destination(s), plus any travel before and after that location:

<table>
<thead>
<tr>
<th>Countries/Cities/Towns</th>
<th>Arrival Date</th>
<th>Departure Date</th>
<th>Accommodations i.e. hotel, camp, family/friends</th>
<th>Overnight in Rural Area?</th>
</tr>
</thead>
<tbody>
<tr>
<td>List all you will visit</td>
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</table>

List all Airports you will be traveling through: ____________________________________________________________________________

Do you have any layovers? ................................................................................................................................. ☐ Yes ☐ No

How long is each layover? __________________________________________________________________________________

Have you traveled outside the United States in the past? ......................................................................................... ☐ Yes ☐ No

Will you be ascending to high altitudes (>7,000 ft.)? ................................................................. ☐ Yes ☐ No

Will you be working in the medical or dental field with exposure to blood or other body fluids? ................................................................. ☐ Yes ☐ No

Will you be working with exposure to animals? ............................................................................................... ☐ Yes ☐ No

Will you potentially have sexual contact with new partner(s)? ........................................................................... ☐ Yes ☐ No
Will you be travelling in/visiting a rural area?  ..............................................................................................................  Yes  No

**Immunization History**
Have you completed the following vaccinations? **You MUST provide Campus Care with a copy of your vaccination record.**

<table>
<thead>
<tr>
<th>Vaccination</th>
<th>Date</th>
<th>Vaccination</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diphtheria-Tetanus-Pertussis (DTaP)</td>
<td></td>
<td>Japanese Encephalitis</td>
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<tr>
<td>Hepatitis A (2 dose series)</td>
<td></td>
<td>Typhoid</td>
<td></td>
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<tr>
<td>Hepatitis B (3 dose series)</td>
<td></td>
<td>Yellow Fever</td>
<td></td>
</tr>
<tr>
<td>Meningitis (Meningococcal)</td>
<td></td>
<td>Varicella</td>
<td></td>
</tr>
<tr>
<td>Measles, Mumps, &amp; Rubela (MMR)</td>
<td></td>
<td>Other</td>
<td></td>
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<tr>
<td>Polio Series</td>
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</tbody>
</table>

Have you ever had a serious reaction to a vaccine? ..............................................................................................................  Yes  No

Have you ever had a Tuberculosis Test? ..........................................................................................................................  Yes  No

Result: __________________________________________ Date: __________________________

Have you ever been prescribed medication to prevent Malaria? ..........................................................................................  Yes  No

What type: ______________________________________ Date: __________________________

**Medical History**
List all recent and past medical problems:

Do you have a history of mental illness including depression & anxiety? .................................................................  Yes  No

Have you recently undergone radiotherapy, chemotherapy or steroid treatment? .........................................................  Yes  No

Are you pregnant, planning pregnancy or breast feeding? .................................................................................................  Yes  No

Would you like to discuss long acting contraceptive options? ..........................................................................................  Yes  No

Would you like to request an extended supply of birth control pills as part of your travel planning? .........................  Yes  No

Will you be traveling with any injectable medications (e.g. testosterone, insulin)? ......................................................  Yes  No

What injectable: ____________________________________________________________

**Allergies**
List all medication and food allergies including the reaction it caused:

**Medications**
List all medication(s) you are currently taking including prescription, over the counter, and herbal medication:

**Questions/Concerns**
List additional questions or concerns that you might have regarding your travel:

Please submit this completed form, vaccination record, and all other pertinent forms promptly so we can schedule your travel consultation appointment. You may drop off the information to OhioHealth Campus Care at Ohio University or email it to campuscare@ohio.edu. Note that the Campus Care email is not secure. Campus Care will contact you within 3 business days to schedule the consultation.