TRAVEL HEALTH ASSESSMENT FORM

Legal Name ____________________________  Last  First  Middle Initial  Preferred Name ____________________________

Student PID Number __________________  Date of Birth ____________  Legal Sex ____________  Preferred Pronouns
(i.e. 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</th>
<th>Overnight in Rural Area?</th>
</tr>
</thead>
<tbody>
<tr>
<td>List all you will visit</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</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? ................................................................dü... ☐ 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.

- Diphtheria-Tetanus-Pertussis (DTaP) Date: 
- Hepatitis A (2 dose series) Date: 
- Hepatitis B (3 dose series) Date: 
- Meningitis (Meningococcal) Date: 
- Measles, Mumps, & Rubela (MMR) Date: 
- Polio Series Date: 
- Japanese Encephalitis Date: 
- Typhoid Date: 
- Yellow Fever Date: 
- Varicella Date: 
- Other What? Date: 

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.