Southwest Utah Public Health Department
International Travel Intake Form

All information is strictly confidential

(*Please Print*)

Today's Date: ____________________

STAMARIL Patient ID: ______________

CLIENT INFORMATION:

Name: ____ Mother's Maiden Name: _________________
LAST FIRST MIDDLE

Address: ____
STREET/P.O. BOX CITY STATE ZIP CODE

Telephone: (_____) ______ - ________ □ Home □ Cell □ Message □ Work

Telephone: (_____) ______ - ________ □ Home □ Cell □ Message □ Work

Email: ____

Birth Date: ______ / ______ / _______ Age: ______ Gender: □ Male □ Female
MO DY YR

Race: □ White □ Black □ Asian □ Indian/American Native □ Native Hawaiian/Pacific Islander □ Other
Hispanic/Latino: □ Yes □ No

If child, name of parent: ____

INSURANCE INFORMATION: (Please bring current insurance card at time of service)

Medicaid: □ Yes □No ID# _______________________

Medicare: □ Yes □No ID# _______________________

Private Insurance: □ Yes □No

Insurance Co. Name: ____________________________________ ID Number: __________________________

Subscriber's Name: _____________________________________ Subscriber's Date of Birth: ______________

Does your insurance cover the cost of immunizations? □ Yes □ No □ Unknown

CONSENT FOR TREATMENT AND PRIVACY NOTICE

I, the patient (or the undersigned if other than the patient), understand that I am responsible for all expenses incurred at the Southwest Utah Public Health Department (SWUPHD) International Travel Clinic on my behalf (or on behalf of the patient). SWUPHD may be able to bill my health insurance, Medicare/Medicaid, but I understand that I am responsible for all co-payments, deductibles, immunizations, counseling fees, and other services not covered by my health insurance, Medicare/Medicaid. I agree to pay all fees at time of service.

I have been given a copy and have read, or have had explained to me, the information contained in the important Vaccine Information Statements. I have had a chance to ask questions, which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccines and request that the vaccines indicated be given to the person named above for whom I am authorized to make this request. I agree that immunization information (only) may be included in a centralized, statewide database and shared with other health care providers as necessary. I HEREBY RELEASE SOUTHWEST UTAH PUBLIC HEALTH DEPARTMENT, AND ITS EMPLOYEES, FROM ALL CLAIMS ARISING FROM SUCH IMMUNIZATIONS, TRAVEL ADVICE AND PRESCRIBED MEDICATIONS.

I have been given a copy of the Health Department's Notice of Privacy Practices and have had an opportunity to ask questions about how my information may be used.

Signature: ____ Today's Date: ____________________

Relationship to Client: □ Self □ Parent □ Legal Guardian □ Other _________________________

TRAVEL INFORMATION

Departure Date: _______________ Return Date: ______________ Total length of trip: ____________________________

Number of people traveling with you: _______________ or number in your tour group __________________

Is this a mission? □ Yes □ No If yes, Country of mission: _____________________ Name of mission: ______________________

If LDS mission, Date entering MTC: ____________________ Location of MTC: ____

(*LDS missionaries, skip to* ***PERSONAL MEDICAL INFORMATION*** *section*)

ITINERARY: ***(Please list in order and include length of time you will be staying at each location including airport stops and layovers)***:

Country City/Area Duration Country City/Area Duration

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____

PURPOSE OF TRIP *(check all that apply)*:

□ Business/work □ Receive medical care □ Humanitarian □ Visit family/friends □ Other _______________
□ Vacation □ Provide medical care □ Missionary □ Adoption

TYPE OF TRAVEL *(check all that apply):*

□ Guided/escorted tour □ Rural areas □ Fixed itinerary □ Usual tourist areas
□ Independent travel □ Urban/major cities □ Flexible itinerary □ Unusual tourist areas

PLANNED ACCOMMODATIONS:

□ Hotel 5 - 3 star □ Live with locals/private home □ Camping
□ Local apartment □ Cruise ship □ Hostels
□ Dorm style lodging □ Remote location □ ____________________

ACTIVITIES (check all that apply to your trip):

□ Tour bus □ Ocean/salt water □ Altitude above 8,000 ft (2500 m) □ Animal contact/hunting
□ Automobile travel □ Scuba diving □ Sun exposure □ Field work
□ Motorcycle/bicycling □ Fresh water; rivers/lakes □ Caving (spelunking) □ Safari
□ Cruise ship travel □ Rafting/kayaking □ Camping/hiking □ _____________________

Check any items you would like to discuss:

□ Altitude sickness □ Risk of malaria □ Food & water safety □ Seeking medical care
□ Insect borne diseases □ Travelers' diarrhea □ Motion sickness □ Other ______________
□ Risk of blood borne infections □ Air travel/jet lag □ Medical care/evacuation insurance

PERSONAL MEDICAL INFORMATION

□ YES □ NO Are you sick today (with moderate to severe fever or acute illness)?
□ YES □ NO Have you previously traveled to any developing country?
□ YES □ NO Did you receive your childhood vaccines?
□ YES □ NO Have you ever had chickenpox disease or the vaccine series? If yes, which one: _____________________
□ YES □ NO Are you currently under a physician's care for any health problem?
□ YES □ NO Do you smoke?
□ YES □ NO Do you have a personal history or family history of Guillain-Barré Syndrome (GBS)?
□ YES □ NO Have you taken cortisone, prednisone, other steroids, anti-cancer drugs, or had radiation treatment in the last 3 months?
□ YES □ NO Do you have any seizure or brain problems?
□ YES □ NO Have you received gamma-globulin or blood transfusions within the past year?
□ YES □ NO Have you received any vaccinations or a TB test in the past 4 weeks?
□ YES □ NO Have you ever taken anti-malarial medication? If yes, what medication: ___________________________
Did you tolerate it well? □ Yes □ No
□ YES □ NO Are you, or will you be at risk for blood borne infections such as: HIV, AIDS, or Hepatitis B or C?
Risks include: blood transfusions, unprotected sexual contacts, use of shared or unsterile needles for injection of drugs or medications, tattoos, acupuncture, injections given in developing countries.
□ YES □ NO *(Females)* Are you pregnant or planning on pregnancy? If yes, when: __________________
□ YES □ NO *(Females)* Are you currently breastfeeding? If yes, how old is the infant: _________________

NAME: ____ AGE ______ TODAY'S DATE: ________________

ALLERGIES

□ YES □ NO Have you ever had a serious or life threatening allergic reaction?
□ YES □ NO Are you allergic to any of the following?
□ Sulfa □ Neomycin □ Streptomycin □ Polymyxin B □ Eggs or chicken protein □ Baker's Yeast □ Gelatin □ Bee Stings

OTHER ALLERGIES: please list: ____

MEDICAL HISTORY □ NONE

(check all that apply)

□ Hepatitis/liver disorders
□ Thrombophlebitis/blood clots
□ Recurrent pneumonia
□ Splenectomy
□ Stomach or bowel conditions
□ Seizures/epilepsy
□ Mental/emotional illness
□ Prostate problems
□ Kidney disease
□ Irregular heart rhythms
□ Heart disease/attacks
□ Diabetes
□ HIV or AIDS
□ Blood thinning meds
□ Recent surgeries
□ Thymus dysfunction (including myasthenia gravis, thymoma, thymectomy)
□ Retinal or visual field changes
□ Psoriasis
□ ________________________
□ Conditions treated with immunosuppressive medications: such as cancer, leukemia, lymphoma, organ transplant, rheumatoid arthritis, Crohn's, ulcerative colitis

MEDICATION INFORMATION □ NONE

(Include prescriptions, contraceptives, vitamins, antacids, antibiotics, herbal, and over-the-counter)

Medication	Reason for Taking	Medication	Reason for Taking

DO NOT WRITE BELOW – FOR OFFICE USE ONLY

IMMUNIZATION INFORMATION

VACCINE	Date of last immunization	Recommend	D / D	VACCINE	Date of last immunization	Recommend	D / D
Chickenpox (Varicella)				Pneumococcal 23			
Hepatitis A (0, 6 mo)				Prevnar 13			
Hepatitis B (0, 1, 6 mo)				Polio IPV/OPV			
Hepatitis A & B (Twinrix) (0, 1, 6 mo) (0, 7, 21 d, 12 mo)				Rabies			
Human Papillomavirus (HPV) (0, 2, 6 mo)				Tetanus/Diphtheria Td			
Influenza				Tetanus/Diphtheria/Pertussis Tdap			
Gamma Globulin				Typhoid Oral			
Japanese Encephalitis				Typhoid Injectable			
Meningococcal				Yellow Fever			
MMR (0, 1 mo) Measles, Mumps, Rubella				Zostavax (shingles)			

D/D = Discussed/Declined
1 = Not covered by insurance
2 = Pt feels don't need it
3 = Personal beliefs
4 = Side effects
5 = Will get/has from PCP
6 = Not enough time before travel
7 = Will get at destination

C = Completed Series

Hx = History of Disease

V1 = Visit Date: ______________________________
V2 = Visit Date: ______________________________
V3 = Visit Date: ______________________________

Malaria prophylaxis recommended □ YES □ NO, patient at low/no risk
Prescription given? □ YES □ NO

NAME: ____ AGE ______ TODAY'S DATE: ________________

PRESCRIPTIONS

Weight: _________________________ lbs/kg ☐ **NO PRESCRIPTIONS GIVEN**

Rx	Dosage	D/D
☐ **Acetazolamide (Diamox)** □ 250 mg tab □ 2.5 mg/kg po bid = _____mg/cap Take 1 tab/cap bid for prevention of AMS	#	
☐ **Atovaquone/Proquanil (Malarone)** □ 250/100 mg tab □ 62.5/25 mg tab □ Take 1 tablet po qd starting 1 day prior to travel to malaria area. Continue taking qd during and x 7 days after leaving area for prevention of malaria. Take with food. □ Take _____ tablet(s) po qd x 3 days for self-treatment of malaria.	#	
☐ **Azithromycin (Zithromax)** □ 250 mg Z-pak □ 200 mg/5 ml (10 mg/kg po qd = _____ ml qd) □ Dispense: □ 15 ml □ 22.5ml □ 30 ml Take _____ tab/dose po qd at onset of travelers' diarrhea x 1-3d or until sx resolve.	#	
☐ **Cefdinir (Omnicef)** □ 300 mg tab □ 125 mg/5 ml (7 mg/kg po bid = _____ ml q bid) Take 1 tab/dose po bid at onset of travelers' diarrhea x 1-5d or until sx resolve.	#	
☐ **Chloroquine Phospate (Aralen)** □ 500 mg tab □ 8.3 mg/salt kg po q wk = _____mg/cap q wk. Mix content of cap w/ food. □ Take 1 tab/dose po starting 1 week prior to travel to malaria area. Cont. taking weekly during travel in, and x 4 weeks after leaving malaria area. □ Take 1 tab/dose po in the AM, then 1 tab six hours later starting 1 day prior to travel to malaria area. One week after first dose, start taking 1 tab weekly for every week of travel in, and x 4 weeks after leaving malaria area.	#	
☐ **Ciprofloxacin (Cipro) 500 mg tab** Take 1 tab po bid at onset of travelers'diarrhea x 1-5d or until sx resolve.	#	
☐ **Dexamethasone (Decadron) 4 mg tab** Take 1 tab po qid until sx improve or pt is down, for tx of AMS.	# 10	
☐ **Doxycycline 100 mg tab** □ Take 1 tablet po daily starting one day prior to travel to malaria area. Cont. taking qd during travel in and x 4 weeks qd after leaving malaria area. □ Take 2 tabs po once a wk starting the day of fresh water exposure, continue weekly during and 1 wk following exposure.	#	
☐ **Epi-Pen** □ 0.3 mg 2-pk □ 0.15 mg 2-pk Use auto-injection syringe as directed for severe allergic reactions.	#	
☐ **Fluconazole (Diflucan) 150 mg tab** Take 1 tab po q wk prn for treatment of yeast infection.	#	
☐ **Levofloxacin (Levaquin) 500 mg tab** Take 1 tab po qd at onset of travelers' diarrhea x 1-5d or until sx resolve.	#	

Rx	Dosage	D/D
☐ **Mefloquine (Lariam)** □ 228 mg base/250 mg salt tab □ 228 mg base/250 mg salt (4.6 mg base/kg = _____ mg/cap) Mix content of cap w/ food. □ Take ____ tab/dose po once weekly starting 2 weeks prior to travel to malaria area. Cont. taking dose once weekly during travel in and x 4 weeks after leaving malaria area. Take w/ food. □ Take tab/dose po daily x 3 days starting three days prior to travel to malaria area. One week after first dose, start taking dose po weekly during travel in and x 4 weeks after leaving malaria area. Take w/ food.	#	
☐ **Nifedipine 10 mg tab** Take 1 tab po initially, then 2 tabs bid for tx of HAPE.	# 10	
☐ **Promethazine (Phenergan) 25 mg tab** Take 1 tab po bid prn to prevent motion sickness/nausea. Start medicine ½ - 1 hour before needed.	#	
☐ **Ramelteon (Rozerem) 8 mg tab** Take 1 tab po at bedtime prn for sleep.	# 10	
☐ **Scopolamine Transderm Pk/4 patches** Apply to bare skin behind 1 ear to prevent motion sickness. Place patch 4 hrs before needed.	#	
☐ **Scopolamine 0.4 mg tab** Take 1-2 tab po q 6 hrs prn to prevent motion sickness.	#	
☐ **Scopolamine Gel 0.25 mg** Apply 0.1 ml to wrist q 6 hrs to prevent motion sickness. Take dose 1 hr before event.	#	
☐ **Xifaxan (Rifaximin) 200 mg tab** Take 1 tab po tid at onset of travelers' diarrhea x 1-3d or until sx resolve.	#	
☐ **TMP/SMX (Bactrim)** □ 160/800 mg DS tab □ 80/400 mg SS tab □ 40/200 mg/5 ml (4 mg TMP/kg po bid =______ ml bid) Take 1 tab/dose po bid at onset of travelers' diarrhea x 1-5d or until sx resolve.	#	
☐ **Artemether/lumifantrine (Coartmen)** Take ____ tablets po as initial dose, then ____ tablets 8 hours later, then ____ tablets bid on days 2 and 3 for self-treatment of malaria. Take w/ food.	# 24	
☐ **Graduated compression stockings** Wear during long distance travel to prevent DVT/PE.	# 1	
☐	#	

D/D = Discussed/Declined

1 = Not covered by insurance/$$	5 = Will get/has from PCP
2 = Pt feels doesn't need it	6 = Not enough time before travel
3 = Personal beliefs	7 = Will get at destination
4 = Side-effects	8 = Already has prescription

Key: **d**-day, **wk**-week, **qd**-every 24 hours, **bid**-every 12 hrs, **tid**-every 8 hrs, **qid**-every 6 hrs, **po**-by mouth, **prn**-as needed, **sx**-symptoms

WRITTEN/VERBAL EDUCATION

□ TRAVAX report for countries visiting
□ U of U International Travel Clinic Book
□ VIS's for vaccines given
□ ____________________________
□ ____________________________
□ ____________________________

□ Immunizations
□ Motion sickness
□ Theft/personal safety
□ Food & water safety
□ Sun protection
□ Health issues
□ Traveler's diarrhea
□ Sexual contacts
□ Travel, health, and medical insurance
□ Insect precautions
□ Animal bites
□ Travel schedule/money/passports
□ Jet lag/air travel/DVT
□ Fresh water exposure/leptospirosis
□ Illness back home

REGION SPECIFIC / OTHER EDUCATION

□ Yellow fever
□ Scuba diving
□ Dengue fever
□ Brucellosis
□ Pregnancy
□ Japanese encephalitis
□ Ocean/beach
□ Schistosomiasis
□ Melioidosis
□ Children
□ Malaria
□ Avian Flu
□ Trypanosomiasis
□ TB
□ ___________________
□ Altitude sickness
□ Chikungunya
□ Leishmaniasis
□ Tick-borne diseases
□ ___________________

Notes:

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Nurse: ____ Date: ________________

Reviewed by: ____________________________________ Date: ________________
Dr. Scott Benson / Dr. Daniel Leung / Dr. Jakrapun Pupaibool

STA00011 Expanded Access Program

Inclusion/Exclusion Criteria (Protocol Amendment 3, dated 28 March 2017)

Subject ID: ______________________________ Date: ______________________________

Check box for **Yes** or **No**

(Place completed form in patients chart)

An individual must fulfill **all of the following criteria** (all must be YES) in order to be eligible for participation in this EAP:

YES	NO	Inclusion Criteria
		Persons in the United States who are at high risk for YF, including researchers, laboratory workers, vaccine production staff, and those who are traveling within 30 days to a YF-endemic region or to a country requiring proof of YF vaccination under IHRs.
		≥9 months of age on the day of vaccination
		An ICF, indicating that Stamaril vaccine (non-US-licensed) is being administered in place of YF-VAX, has been signed and dated by persons ≥ 18 years of age.
		An assent form has been signed and dated by persons 7 years to < 18 years of age, and ICF has been signed and dated by parent(s) or guardian(s) for persons ≥ 9 months to < 18 years of age.

An individual fulfilling any of the following criteria (all must be NO) is to be **excluded** from participation in this EAP:

YES	NO	Exclusion Criteria
		Age < 9 months
		Breastfeeding, if the nursing cannot be discontinued for at least 14 days following vaccination. **Note**: Yellow Fever vaccine virus may be transmissible via breast milk by nursing mothers who are vaccinated during the final 2 weeks of pregnancy or post-partum. Following transmission, infants may develop encephalitis. The minimum time of discontinuation of breastfeeding for 14 days after vaccination is based on the expected clearance of live-attenuated vaccine virus.
		Immunosuppression, whether congenital or idiopathic, including for example, leukemia, lymphoma, other malignancies, and patients who are receiving immunosuppressant medications (e.g., systemic corticosteroids [greater than the standard dose of topical or inhaled steroids], alkylating drugs, antimetabolites, or other cytotoxic or immunomodulatory drugs) or radiation therapy, or organ transplantation.
		Symptomatic HIV infection
		Known hypersensitivity to the active substance or to any of the excipients of Stamaril vaccine or to eggs or chicken proteins
		Asymptomatic HIV infection when accompanied by evidence severe immune suppression. **Note**: Evidence of severe immune suppression includes CD4+ T-cell counts < 200/mm3 (or < 15% total lymphocytes in children aged < 6 years), or as determined by the HCP.
		History of thymus dysfunction (including myasthenia gravis, thymoma, thymectomy).
		Moderate or severe febrile illness or acute illness **Note**: Participation in the EAP can be reassessed when moderate or severe febrile illness or acute illness has resolved.

Inclusion/Exclusion Criteria, continued

An individual fulfilling any of the following criteria may participate in this EAP, if travel cannot be avoided, and if in the judgment of the HCP, the benefits of vaccination outweigh potential risks:

Check box if applicable	Precautions
	Pregnancy Note: Live attenuated virus vaccines given to pregnant women might be capable of crossing the placenta and infecting the fetus. No animal reproductive or development studies have been conducted with Stamaril vaccine and the potential for risk to the fetus is unknown. Stamaril vaccine should not be used in pregnant woman, unless when clearly needed and following an assessment of the risks and benefits. Vaccination during pregnancy must be reported to Sanofi Pasteur. Report to sanofi on the Pharmacovigilance Reporting Form
	Age ≥ 60 years Note: Some serious and potentially fatal ARs including systemic and neurological reactions persisting more than 48 hours (YF vaccine-Associated Viscerotropic Disease and YF vaccine-Associated Neurotropic Disease) appear to occur at higher frequencies among individuals ≥ 60 years.
	Asymptomatic HIV infection with moderate immune suppression or no evidence of immune suppression. Note: Persons with asymptomatic HIV infection with moderate immune suppression or no evidence of immune suppression, as determined by the HCP, may participate in the EAP. The rate of seroconversion following vaccination is reduced and appears to depend on HIV viral load and CD4+ T-cell count. Evidence of moderate immune suppression includes CD4+ T-cell counts 200–499/mm^3 (or 15%–24% of total lymphocytes in children aged < 6 years), or as determined by the HCP. No evidence of immune suppression includes CD4+ T-cell counts ≥ 500/mm^3 or ≥ 25% of total lymphocytes for children aged < 6 years, or as determined by the HCP.

Signed_______________________________________ Date______________________