Southwest Utah Public Health Department

International Travel Intake Form

All information is strictly confidential

Today's Date: _____

Patient Last Name	First Name	MI	Date of Birth (mm/dd/yyyy)	Age

Race	Ethnicity	Language	Gender
☐ White ☐ Black ☐ Asian ☐ American Indian ☐ Alaskan Native ☐ Pacific Islander	☐ Hispanic ☐ Non Hispanic		☐ Male ☐ Female

Address	City	State	Zipcode

Primary Phone #	Best Form of Contact	Email:
	☐ Phone Call ☐ Text ☐ Email	

Primary Health Insurance	Policy #	Policy Holder (Exact Name listed on Card)

Insurance Policy Holder Date of Birth (mm/dd/yy)	Relationship to Patient	Address of Policy Holder

I certify that the information I have provided is true and accurate. 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 this information may be shared with schools, day care centers, health care providers and others when deemed medically necessary. I HEREBY RELEASE SOUTHWEST UTAH PUBLIC HEALTH DEPARTMENT, AND ITS EMPLOYEES, FROM ALL CLAIMS ARISING FROM SUCH IMMUNIZATIONS.

I UNDERSTAND THE BILLING OF MEDICAL INSURANCE DOES NOT GUARANTEE PAYMENT AND THAT I AM RESPONSIBLE FOR ANY UNPAID BALANCE.

We are required to inform you of our privacy practices for the information we collect and keep about you. 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.

Full Name: _____Signature: _____ Date: _____

Relationship to Patient: ☐ **Self** ☐ **Parent** ☐ **Legal Guardian** ☐ **Other**

SECTION 1: TRAVEL INFORMATION

Departure Date: _____ Return Date: _____ Total Length of Trip: _____

Number of people traveling with you: _____ Or number in your tour group: _____

ITINERARY: Please list your itinerary in order and include the length of time you will be staying at each location including airport stops and any layovers.

Country	City/Area	Duration	Country	City/Area	Duration
☐ See attached itinerary			4. _____	_____	_____
1._____	_____	_____	5. _____	_____	_____
2._____	_____	_____	6. _____	_____	_____
3._____	_____	_____	7. _____	_____	_____

PURPOSE OF TRIP: Check all that apply

☐ Business/work ☐ Receive medical care ☐ Provide medical care ☐ Visit family/friends
☐ Adoption ☐ Vacation ☐ Non-LDS mission/humanitarian ☐ Other: _____

☐**LDS mission name & MTC location

_____

****LDS Mission Skip to Section 3: Medical History**

NAME: _____ Date: _____

SECTION 2: ADDITIONAL TRAVEL

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: 3-5 star ☐ Live with locals/private home ☐ Camping
☐ Local apartment ☐ Cruise ship ☐ Hostels
☐ Dorm style lodging ☐ Remote location ☐ Other: _____

ACTIVITIES: Check all that apply

☐ Tour bus ☐ Ocean/salt water ☐ Altitude above 8,000 ft (2500 m) ☐ Animal contact/huntin
☐ Automobile travel ☐ Scuba diving ☐ Sun exposure ☐ Field work
☐ Motorcycle/bicycle ☐ 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 ☐ Risk of blood borne infections
☐ Air travel/jet lag ☐ Medical care/evacuation insurance ☐ Other: _____

SECTION 3: MEDICAL HISTORY

PERSONAL MEDICAL INFORMATION	Yes	No
Are you sick today (with moderate to severe fever or acute illness)?		
Have you previously traveled to any developing country?		
Did you receive your childhood vaccines?		
Have you ever had chickenpox disease or the vaccine series? If yes, which one: _____		
Are you currently under a physician's care for any health problem?		
Do you smoke?		
Do you have a personal history or family history of Guillain-Barré Syndrome (GBS)?		
Have you taken cortisone, prednisone, other steroids, anti-cancer drugs, or had radiation in the last 3 months?		
Do you have any seizure or brain problems?		
Have you received gamma-globulin or blood transfusions within the past year?		
Have you received any vaccinations or a TB test in the past 4 weeks?		
Have you ever taken anti-malarial medication? If yes, what medication: _____ Did you tolerate it? ____		
Are you, or will you be, at risk for blood borne infections such as HIV, AIDS, or Hepatitis B and C?		
(Females) Are you pregnant or planning on pregnancy? If yes, when: _____		
(Females) Are you currently breastfeeding? If yes, how old is the infant: _____		

MEDICAL HISTORY

☐ **NONE** ☐ Hepatitis/liver disorders ☐ Seizures/epilepsy ☐ Heart disease/attacks
☐ Thrombophlebitis/blood clots ☐ Mental/emotional illness ☐ Diabetes ☐ Retinal or visual field changes
☐ Recurrent pneumonia ☐ Prostate problems ☐ HIV or AIDS ☐ Splenectomy
☐ Kidney disease ☐ Blood thinning meds ☐ Psoriasis ☐ Stomach or bowel conditions
☐ Irregular heart rhythms ☐ Recent surgeries ☐ Thymus dysfunction (including myasthenia gravis, thymoma, thymectomy)
☐ Conditions treated w/immunosuppressive medications: cancer, leukemia, lymphoma, organ transplant, rheumatoid arthritis, Crohn's, ulcerative colitis

ALLERGIES	Yes	No
Have you ever had a serious or life-threatening allergic reaction?		
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 _____		

MEDICATION INFORMATION ☐ **NONE**

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

Medication	Reason for Taking	Medication	Reason for Taking

NAME: _____ Date: _____

STOP! **DO NOT WRITE BELOW – FOR OFFICE USE ONLY** **STOP!**

IMMUNIZATION INFORMATION

Vaccine	Date of last immunization	Recommend	D/D	Vaccine	Date of last immunization	Recommend	D/D
Chickenpox (Varicella)				Measles, Mumps, Rubella (MMR)			
Cholera				Pneumococcal 23			
COVID-19				Prevnar 13 / 15 / 20			
Hepatitis A				Polio IPV/OPV			
Hepatitis B				Rabies			
Heplisav-B				Tetanus/Diphtheria (TD)			
**Hepatitis A & B (Twinrix) ☐ Twinrix ☐ Accelerated				Tetanus/Diphtheria/Pertussis (Tdap)			
Human Papillomavirus (HPV)				Typhoid Oral			
Influenza				Typhoid Injectable			
Japanese Encephalitis				Yellow Fever			
Meningococcal				Shingles (Zostavax/Shingrix)			
MenB							

****Twinrix (0, 1mo, 6mo) OR Accelerated (0, exactly 7d, 21-30d, 12mo)**

D/D = Discussed/Declined

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

Visits

V1 = Visit Date: _____
V2 = Visit Date: _____
V3 = Visit Date: _____
V4 = Visit Date: _____

Key: **C = Completed Series** **Hx dx= History of Disease** **Hx vax= History of Childhood Vaccination**

PRESCRIPTIONS

Weight: _____ lbs/Kg ☐ **NO PRESCRIPTIONS GIVEN**

Rx	Dosage	D/D
Acetazolamide (Diamox) □ 250 mg ta □ 2.5 mg/kg po bid = _____mg/cap Take 1⁄2 to 1 tab/cap bid for prevention of AMS	#	
Atovaquone/Proquanil (Malarone) □ 250/100 mg tab □ Take 1 tablet po qd starting 1 day prior to travel to malaria area. Continue taking qd during and x7 days after leaving area for prevention of malaria. Take with food. □ Take _____ tablet(s) po qd x3 days for malaria self-treatment **Pediatric Dosing: Take with food** □ 62.5/25 mg tab □ Take _____ tablet(s) po qd starting 1 day prior to travel to malaria area. Continue taking qd during and x7d after leaving area for prevention.		
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 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 1-3d 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.		

Rx	Dosage	D/D
Doxycycline 100 mg tab (missionaries) (Only missionaries traveling to malaria area/code #4) □ Take 1 tablet po qd starting two days prior to leaving the USA. Take with food.	# 28	
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.		
Mefloquine (Lariam) □ 228 mg base/250 mg salt tab (4.6 mg base/kg = _____ mg/cap) Mix cap w/ food. □ Take ____ tab/dose po once weekly starting 2wk prior to travel to malaria area. Cont. taking x1wk during travel in and x4wk 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	
Scopolamine Transderm Pk/4 patches Apply to bare skin behind ear to prevent motion sickness. Place 4hrs before need.		
Xifaxan (Rifaximin) 200 mg tab Take 1 tab po tid at onset of travelers' diarrhea x 1-3d or until sx resolve.	# 10	
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.		
Graduated compression stockings Wear during long distance travel to prevent DVT/PE.		
Epi □ EPI PEN 0.3 mg □ EPI PEN JR 0.15 mg		

NAME: _____ Date: _____

WRITTEN/VERBAL/ELECTRONIC EDUCATION

☐ TRAVAX report for countries visiting
☐ Immunizations
☐ Food & water safety
☐ Traveler's diarrhea
☐ Insect precautions
☐ Jet lag/air travel/DVT
☐ Travel video
☐ U of U International Travel Clinic Book
☐ Motion Sickness
☐ Sun protection
☐ Sexual contacts
☐ Animal bites
☐ Fresh water exposure/leptospirosis
☐ VIS's for vaccine given
☐ Theft/personal safety
☐ Health issues
☐ Travel, health, and medical insurance
☐ Travel schedule/money/passports
☐ Illness back home

REGION SPECIFIC/OTHER EDUCATION

☐ Altitude sickness
☐ Anthrax
☐ Arboviral
☐ Avian flu
☐ Bartonellosis
☐ Brucellosis
☐ Chikungunya
☐ Children
☐ Cholera
☐ COVID-19
☐ Dengue fever
☐ Ebola virus
☐ Enterovirus
☐ Filarial infection
☐ Hantavirus
☐ Helminths
☐ Hepatitis C
☐ Japanese encephalitis
☐ Lassa fever
☐ Leishmaniasis
☐ Leptospirosis
☐ Lyme
☐ Malaria
☐ Melioidosis
☐ Meningococcal
☐ MERS Coronavirus
☐ MMR
☐ Ocean/beach
☐ Plague
☐ Pregnancy
☐ Rabies
☐ Rickettsial infection
☐ Schistosomiasis
☐ Scuba diving
☐ STIs
☐ Tick-borne diseases
☐ Travelers diarrhea
☐ Trypanosomiasis
☐ Tuberculosis (TB)
☐ Typhoid
☐ Viral hemorrhagic
☐ West Nile
☐ Yellow fever
☐ Zika
☐

TYPHOID

☐ Yes ☐ No Typhoid vaccine given
☐ Yes ☐ No Education

YELLOW FEVER

☐ NOT APPLICABLE
□ Yes □ No Meets criteria for yellow fever vaccine
□ Yes □ No International Certificate of Vaccine or Prophylaxis (ICVP)
□ Yes □ No Observed client for 15 minutes
□ Yes □ No Issued waiver for yellow fever vaccine

Notes:

Vaccine	Lot #	Dose	Category	Site	Payment Information
					□ Cash _____ □ Card _____
					□ Check # _____ □ Voucher
					RN:
					Date:
					Reviewed by: Dr. Jakrapun Pupaibool, MD/ Theresa Sofarelli, PA-C/ Dr. Daniel Leung, MD
					Date: