795 E. Second Street, Suite 1
Pomona, CA 91766-2007
Main 909-706-3730 * Fax 909-706-3731

WesternU Travel Health Center

Email: travelcenter@westernu.edu or Fax: 909-706-3731

Please complete all of the following and then return the forms to the Travel Center in order to schedule your appointment.

Today's date: _____

Name: _____ Sex: M / F Date of birth: _____

Address: _____

City, State, Zip: _____

Phone number(s): _____

Physician name: _____

Physician phone/fax number: _____

Physician mailing address: _____

Information About Your Travel Plans:

Purpose of travel (e.g. business, pleasure, medical work): _____

Briefly describe your travel plans/activities:_____

List destination city and country in the order you will be visiting	Date of Arrival	Date of Departure	Length of Stay

Will you be:	**Yes**	**No**
Visiting ONLY urban (cities) areas? If no, please explain:		
Staying ONLY in hotels? If no, please explain:		
Traveling to high altitudes (> 10,000 ft. or 2,000 m)?		
Visiting either family or friends?		
Working with exposure to animals?		
Handling blood/blood products or working in a hospital or clinic?		
Engaging in sexual contact with new partner?		
Using unsterile or shared needles for injecting drugs or medications?		

What concerns related to your travel do you have? _____
_____

Are you covered by a health insurance plan while overseas? Yes / No

Allergies (check all that apply)

	No known drug allergies		No known food allergies
Have you ever had an allergic reaction to any of the following?			
	Bee stings		Anti-malarials (e.g., Aralen, Larium, Malarone)
	Eggs		Erythromycin/ Neomycin
	Thimerosal		Tetracyclines (e.g., minocin, doxycycline)
	Gelatin		Sulfa drugs (e.g., Bactrim, Septra)
Other			

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MEDICATION INFORMATION

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

Medication	Reason for taking medication

VACCINATION HISTORY

Vaccine	Date of Last Immunization	Vaccine	Date of Last Immunization
Gamma globulin		Pneumococcal	
Hepatitis A		Polio/IPV/OPV	
Hepatitis A & B		Rabies	
Hepatitis B		Tetanus/Diphtheria	
Herpes Zoster		Tetanus/Diphtheria/ Pertussis	
HPV (human papilloma virus)		TB PPD skin test	
Immune globulin		Typhoid (injectable)	
Influenza		Typhoid (oral)	
Japanese Encephalitis		Varicella /chickenpox	
Meningococcal		Yellow fever	
Measles/Mumps/Rubella (MMR)			

Do YOU or other family members have any of the following medical conditions? (Check all that apply)

	You	Family History		You	Family History		You	Family History
Anemia			Gout			Prostate disease		
Asthma			Hearing problems			Psoriasis/Skin disease		
Blood clots			Heart disease			Psychiatric illness		
Cancer			Hepatitis/Liver disease			Sickle cell disease		
Depression			High blood pressure			Splenectomy		
Diabetes			High cholesterol			Stomach ulcer		
Ear infections			HIV/AIDS			Stroke		
Epilepsy/Seizure Disorder			Immune system disorders			Thymus disease / Thymectomy		
Eye problems			Kidney disease			Thyroid problems		
G6PD deficiency			Lung disease			Other		

Do you have any conditions treated with immunosuppressive medications? (circle all that apply)

Cancer Leukemia HIV/AIDS Organ Transplant Rheumatoid Arthritis Chemotherapy

Crohn's disease Ulcerative Colitis Other:_____

Questions for Women:

Are you pregnant, suspect you may be pregnant, or trying to become pregnant? Yes / No

If pregnant, how many weeks? _____ Are you breastfeeding? Yes / No

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Travel Health Center

Consent for Release of Protected Health Information

I, _____ born on _____, hereby authorize:
(Name)

Western University Travel Health Center
795 E Second Street, Suite 1
Pomona CA, 91766-2007

To disclose the following information (check all that apply):
- ☐ Immunization information
- ☐ Lab Work (specific dates if applicable)
- ☐ Other:_____

To: _____

_____

_____

Phone: _____ Fax: _____

I understand that certain records * are protected by Federal and / or State laws which prohibit the release of such records. The Travel Health Center will comply with such laws. By signing this consent on this _____day of _____ , 20_____ , I agree with all the provisions stated in this consent for the release of information. I also understand that I may revoke this consent at any time and regardless, this consent expires one year from the above written date.

_____ _____
Signature of Traveler/Parent/Guardian Signature of Witness

_____
Printed Name of Traveler/Parent/Guardian

Prohibition on redisclosure: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulations (42 CFR Part 2) prohibit you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose. Federal Regulations state that any person who violates any provision of this law shall be fined not more than $500, in the case of a first offense, and not more than $5,000 in the case of each subsequent offense.

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Vaccine Consent Form

Today's Date: _____

Please Print

Name:	Date of Birth:	Sex: Male Female
Address:		Phone:
City/State/Zip:		
Physician Name:		Phone:

The vaccines to be administered today are:

	Hepatitis A (HAV)		**Polio (IPV)**
	Hepatitis B Vaccine (HAB) Series		Shingles Vaccine
	Hepatitis A/B Series		Tetanus and Diphtheria (Td)
	Influenza (TIV) / (LAIV)		Tetanus, Diphtheria, &Acellular Pertussis (Tdap)
	Japanese Encephalitis (Ixiaro)		TB PPD Skin test
	Measles, Mumps, and Rubella (MMR) Series		Typhoid (IM and PO formulations)
	Meningococcal		Varicella Series
	Pneumococcal		Yellow Fever
	Rabies Series		

I have been informed of and understand the risks associated with both domestic and international travel. I have been provided with information on each vaccination recommended. I have read, and/or have had the vaccination information explained to me. I have had a chance to ask questions and they have been answered to my satisfaction. I understand that should I refuse to consent to any of the recommended vaccinations, that I do so at my/their own risk. I understand the benefits and risks of the vaccinations.

Female Traveler Only	
I understand there are potential risks and side effects that may be harmful to a developing fetus. To the best of my knowledge, I:	
_____ (initials) am ***NOT*** pregnant.	_____ (initials) **AM** pregnant.

My signature indicates that I am requesting that the vaccine(s) indicated above be administered to me (or my child as named above) today.

_____ _____

Patient or Parent/Guardian Signature Date