

INTERNATIONAL TRAVEL CLINIC - LDS MISSIONARIES

TODAY'S DATE _____
 NAME: _____ DOB: _____ AGE: _____ Phone # _____

TRAVEL INFORMATION

Date entering MTC _____ MTC Location _____ Length of Mission _____
 Country of Mission _____ Name of Mission _____

PERSONAL MEDICAL INFORMATION

- YES NO - Have you previously traveled to any developing country?
- YES NO - Did you receive your childhood vaccines?
- YES NO - Have you ever had chicken pox disease or the vaccine series?
- YES NO - Are you currently under a physicians care for any health problem?
- 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 at risk for blood born infections such as: HIV, AIDS, or Hepatitis B and C?
 (Risks include: blood transfusions, unprotected sexual contacts, use of shared or un-sterile needles for injection of drugs or medications, tattoos, acupuncture, injections given in developing countries.)
- YES NO - (Females) Is there any chance you could be pregnant?

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 Baker's Yeast Gelatin Bee Stings
- OTHER ALLERGIES please list: _____

PAST MEDICAL HISTORY (check all that apply)

- Hepatitis/liver disorders Myesthesia gravis Prostate problems Diabetes
- Thrombophlebitis/blood clots Seizures/epilepsy Kidney disease Heart disease/attacks
- Recurrent pneumonia Mental /emotional illness Irregular heart rhythms HIV or AIDS
- Splenectomy Thymus disease/thymectomy Blood thinning meds Psoriasis
- Stomach or bowel conditions Retinal or visual field changes Recent surgeries
- Problems treated with immunosuppressive medications (cancer, leukemia, lymphoma, organ transplant, rheumatoid arthritis, Crohns, ulcerative colitis)
- List any other medical problems: _____

NONE

MEDICATION INFORMATION

(List any medications you are taking, include prescriptions, contraceptives, vitamins, antacids, antibiotics, herbal, and over-the-counter)

Medication	Reason for Taking

Medication	Reason for Taking

Southwest Utah Public Health Department- Travel Intake Form
All information is strictly confidential (PLEASE PRINT)

CLIENT INFORMATION:

Name: _____ Mother's Maiden Name: _____
Last First MI

Address: _____
Street / P. O. Box City State Zip Code

Telephone: (____) _____ - _____ Circle One: Home Cell Message Work

Telephone: (____) _____ - _____ Circle One: Home Cell Message Work

Birth Date: ____/____/____ Age: _____ Gender: Male Female
M D YR

Race: White Black Asian Other Indian/Am. Native Native Hawaiian/Pacific Islander

Hispanic/Latno: Yes No

Medicaid: Yes No ID Number: _____

Medicare: Yes No ID Number: _____

Private Insurance: Yes No Insurance Company: _____
Subscriber's Name: _____ Subscriber's Date of Birth: _____

If no insurance and you wish to have assistance with the cost of vaccines:
Gross Monthly Income: \$ _____ Number of Household/Family Member: _____

If child, name of parent: _____

CONSENT/PRIVACY

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 insurance, Medicaid/Medicare plan. 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 Vaccine Information Statement(s) about the disease(s). I have had a chance to ask questions, which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) and request that the vaccine(s) 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, state-wide database and shared with other health care providers as necessary. I HEREBY RELEASE THE SOUTHWEST UTAH PUBLIC HEALTH DEPARTMENT, AND THEIR EMPLOYEES, FROM ALL CLAIMS ARISING FROM SUCH IMMUNIZATIONS, TRAVEL ADVICE AND PRESCRIBED MEDICATION.

I have been provided with a copy of SWUPHD's Notice of Privacy Practices.

Signature _____ Date _____

For Office Use Only
TRAVEL VISIT CHARGES

_____ Missionary

\$25

\$ _____ Total Consultation Fees

\$ _____ Total Immunization Charges

\$ _____ Other _____

Paid By:

\$ _____ Amount Received

Card / Cash / Check / Medicaid / Billed _____