



ST. CLOUD STATE UNIVERSITY
MEDICAL CLINIC PHARMACY LAB HEALTH PROMOTION

TRAVEL HEALTH CLINIC REGISTRATION

Date _____

Name _____

Telephone _____

Travel Specifics

Travel destination (s) in the order of travel _____

Date of departure _____ Return date _____

Purpose of travel: ___ School related Which school? _____

___ Pleasure ___ Business ___ Other _____

Have you traveled outside the United States before? ___ Yes ___ No

If yes, where and when? _____

Will you be: Yes No

___ ___ Visiting **ONLY** urban areas? If no, explain _____

___ ___ Staying **ONLY** in hotels? If no, explain _____

___ ___ Visiting friends and/or family _____

___ ___ Ascending to high altitudes in the mountains?

ALLERGIES:

___ No known drug allergies

___ Vaccines

___ Other

___ No known food allergies

___ Latex/metal

___ Eggs

___ Bee stings

IMMUNIZATIONS:

1. Were you born in the United States? Yes No If not where? _____

2. Have you had the following routine and travel related immunizations? Please check and give the dates below.

Yes No

Tetanus/diphtheria/Pertussis

MMR

Yes No

Hepatitis B

Polio Vaccine

Yes No

Chickenpox

Influenza

Yes No

Typhoid

Yes No

Yellow Fever

Yes No

Hepatitis A

Yes No

Meningococcal

Rabies

Pneumococcal

Malaria

HEALTH HISTORY

Yes No

Any History of hospitalizations?

Any history of surgery?

Any history of Anxiety/depression

Any history of Asthma?

Any Immune System deficiency?

Are you currently under the care of health care Provider?

Please list other chronic or acute medical conditions? _____

Women only: Date of your last menstrual period? _____ Are you or could you possibly be pregnant? Yes No

Current prescription and over the counter medications: _____

List questions or concerns you might have regarding your travel: _____

We recommend that you visit the following website prior to your visit for specifics on your travel destination:

www.CDC.gov/travel