2 Health Center Drive
Athens, OH 45701
Tel: 740.592.7100, Fax: 740.592.7112

TRAVEL HEALTH ASSESSMENT FORM

_____ _____
Legal Name Last First Middle Initial Preferred Name

_____ _____ _____ _____
Student PID Number Date of Birth Legal Sex Preferred Pronouns
(ie. he/him, she/her, they/their)

_____ _____ _____
Preferred Mailing Address Primary Contact Number Primary E-mail

Travel Specifics
Purpose of Trip:

☐ School Related Study What Program? _____
☐ Pleasure ☐ Business ☐ Other: _____

Does your program require the completion of a medical form/physical by a medical provider? ..... ☐ Yes ☐ No

What will you be doing on this trip? _____

_____

Are you traveling alone, with family/friends, in a group? _____

Departure Date from United States: _____ Return Date to United States: _____

List your destination(s), plus any travel before and after that location:

Countries/Cities/Towns List all you will visit	Arrival Date	Departure Date	Accommodations i.e. hotel, camp, family/friends	Overnight in Rural Area?

List all Airports you will be traveling through: _____

Do you have any layovers? ..... ☐ Yes ☐ No

How long is each layover? _____

Have you traveled outside the United States in the past? ..... ☐ Yes ☐ No

Will you be ascending to high altitudes (>7,000 ft.)? ..... ☐ Yes ☐ No

Will you be working in the medical or dental field with exposure to blood or other body fluids? ..... ☐ Yes ☐ No

Will you be working with exposure to animals? ..... ☐ Yes ☐ No

Will you potentially have sexual contact with new partner(s)? ..... ☐ Yes ☐ No

Will you be travelling in/visiting a rural area? ..... Yes No

Immunization History

Have you completed the following vaccinations? **You MUST provide Campus Care with a copy of your vaccination record.**

○ Diphtheria-Tetanus-Pertussis (DTaP)	Date:	○ Japanese Encephalitis	Date:
○ Hepatitis A (2 dose series)	Date:	○ Typhoid	Date:
○ Hepatitis B (3 dose series)	Date:	○ Yellow Fever	Date:
○ Meningitis (Meningococcal)	Date:	○ Varicella	Date:
○ Measles, Mumps, & Rubela (MMR)	Date:	○ Other What?	Date:
○ Polio Series	Date:		

Have you ever had a serious reaction to a vaccine? ..... ☐ Yes ☐ No

Have you ever had a Tuberculosis Test? ..... ☐ Yes ☐ No

Result:_____ Date:_____

Have you ever been prescribed medication to prevent Malaria? ..... ☐ Yes ☐ No

What type:_____ Date:_____

Medical History

List all recent and past medical problems:

Do you have a history of mental illness including depression & anxiety? ..... ☐ Yes ☐ No

Have you recently undergone radiotherapy, chemotherapy or steroid treatment? ..... ☐ Yes ☐ No

Are you pregnant, planning pregnancy or breast feeding? ..... ☐ Yes ☐ No

Would you like to discuss long acting contraceptive options? ..... ☐ Yes ☐ No

Would you like to request an extended supply of birth control pills as part of your travel planning? ..... ☐ Yes ☐ No

Will you be traveling with any injectable medications (e.g. testosterone, insulin)? ..... ☐ Yes ☐ No

What injectable: _____

Allergies

List all medication and food allergies including the reaction it caused:

Medications

List all medication(s) you are currently taking including prescription, over the counter, and herbal medication:

Questions/Concerns

List additional questions or concerns that you might have regarding your travel:

Please submit this completed form, vaccination record, and all other pertinent forms promptly so we can schedule your travel consultation appointment. You may drop off the information to OhioHealth Campus Care at Ohio University or email it to campuscare@ohio.edu. Note that the Campus Care email is not secure. Campus Care will contact you within 3 business days to schedule the consultation.