ASBURY COLLEGE
STUDENT HEALTH SERVICE
One Macklem Drive • Wilmore, KY 40390-1198 • Phone: (859) 858-3511, ext. 2277 • Fax: (859) 858-0003

FOREIGN TRAVEL QUESTIONNAIRE

*You must complete and return this form to Student Health Service **BEFORE** you will be scheduled an appointment with the Foreign Travel Nurse.* ***Please print clearly.***

Name:	Gender: M ☐ F ☐	Date of birth: / /	Age:
Address:	City:	ST:	Zip:
Phone: / / , ext (cell phone) / /	email:		
Have you traveled internationally within the past five years?	yes ☐ no ☐		
Have you been seen previously at Asbury College SHS for foreign travel?	yes ☐ no ☐		
Do you have records of prior travel immunizations in a yellow book (World Health Organization shot record)? yes ☐ no ☐ **→If yes, please bring it to your appointment.** **→If no, please submit a copy of your immunization record with this form, if not already on file at SHS.**			

✈✈✈ TRAVEL ITINERARY ✈✈✈

Date of departure from USA: ___/___/___	Date of return to USA: ___/___/___

Please list in order of travel (include planned activities and side trips/excursions):

	Country	Region/City	Length of Stay
1			
2			
3			
4			

Traveling: ☐ alone ☐ w/group (name): Group leader:

Areas visiting: ☐ urban ☐ rural ☐ urban & rural ☐ remote

Accomodations: (✓all that apply) ☐ hotel ☐ apartment ☐ missionary home ☐ national home ☐ camping ☐ ship ☐ other (describe:) _____

Activity: ☐ mission work ☐ medical work ☐ construction ☐ work with children ☐ contact with animals ☐ visiting friends/relatives ☐ vacation ☐ cruise ☐ study ☐ altitude risk ☐ adventure ☐ rafting ☐ scuba diving ☐ other (describe):

✈✈✈ GENERAL MEDICAL ✈✈✈

Allergies: ☐ none known ☐ eggs ☐ nuts ☐ yeast ☐ gelatin ☐ latex
☐ other foods:

☐ penicillin ☐ sulfa ☐ thimerosal ☐ other drugs:

☐ serious reaction to vaccine (describe): date: / /

☐ bee stings / insect bites (If checked) Do you have a current Epi-pen? ☐ yes ☐ no

Medical Conditions (✓all that apply)?

☐ seizures ☐ psychiatric or depression history ☐ insomnia

☐ heart / blood pressure ☐ blood clotting ☐ DVT (deep vein thrombosis)

☐ stomach ☐ liver ☐ kidney ☐ skin condition ☐ eye ☐ thymus

☐ cancer ☐ steroid therapy ☐ photosensitivity ☐ AIDS/HIV or immune deficiency

☐ other : _____

Have you received immunoglobulin or blood products during the past 12 months? ☐ yes ☐ no

If yes, what? _____ date: / /

Hospitalizations? ☐ yes ☐ no	If yes, what?		date: / /
Surgeries? ☐ yes ☐ no	If yes, what?		date: / /

Current medications (include RX, OTC & herbals):	

Other medical conditions/concerns:

Females Only:

Date of last menstrual period: / /	Are you pregnant? ☐ yes ☐ no
Using birth control? ☐ yes ☐ no If yes, what:	

I attest that the above information is accurate and complete to the best of my knowledge. I understand that because of my participation in this trip I will be advised by the SHS of required &/or recommended immunizations and travel precautions regarding my health. It is my responsibility to comply with their recommendations. I understand that refusing recommended immunizations or medications could result in serious medical illness. I understand this consultation does not entail a medical clearance for foreign travel. I will not hold Asbury College or the Student Health Service responsible for contracting diseases or illnesses associated with this trip.

	/ /
Student Signature	Date