

Travelers' Name: _____ Date of Birth: ____ / ____ / ____

School Program: _____

Today's Date: ____ / ____ / ____

ITINERARY:

Departure Date: ____ / ____ / ____

Destination: _____ Total Length of Stay: _____

Destination: _____ Total Length of Stay: _____

Destination: _____ Total Length of Stay: _____

Destination: _____ Total Length of Stay: _____

LODGING (Check all that apply):

- | | | |
|--|--------------------------------------|--|
| <input type="checkbox"/> Luxury/Business Hotel | <input type="checkbox"/> Guest House | <input type="checkbox"/> Family/Friends |
| <input type="checkbox"/> Homestay | <input type="checkbox"/> Rental | <input type="checkbox"/> Dorm |
| <input type="checkbox"/> Camping | <input type="checkbox"/> Cruise Ship | <input type="checkbox"/> Other (specify _____) |

ANTICIPATED ACTIVITIES (Check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> Scuba diving | <input type="checkbox"/> High-altitude travel (>6,000-8,000 ft, > 1,829-2,438 m) |
| <input type="checkbox"/> Caving | <input type="checkbox"/> Desert travel |
| <input type="checkbox"/> Jungle travel | <input type="checkbox"/> Camping/hiking |
| <input type="checkbox"/> Kayaking/Rafting | <input type="checkbox"/> Solo travel |
| <input type="checkbox"/> Bicycling | <input type="checkbox"/> Driving |
| <input type="checkbox"/> Motorcycle Riding | <input type="checkbox"/> Clinical Caregiving |
| <input type="checkbox"/> Blood or Human Tissue Handling | <input type="checkbox"/> Animal Blood or Tissue Handling |
| <input type="checkbox"/> Adventurous/Exotic Cuisine | <input type="checkbox"/> Swimming in fresh-water lakes/streams/rivers |
| <input type="checkbox"/> Sex | <input type="checkbox"/> Mountain climbing |
| <input type="checkbox"/> - O with current partner | <input type="checkbox"/> - O with ropes |
| <input type="checkbox"/> - O with new partner(s) | <input type="checkbox"/> - O without ropes |

ALLERGY HISTORY:

Are you allergic or hypersensitive to any of the following (check all that apply):

- | | |
|---------------------------------------|---|
| <input type="checkbox"/> Eggs | <input type="checkbox"/> Neomycin |
| <input type="checkbox"/> Yeast | <input type="checkbox"/> Gelatin |
| <input type="checkbox"/> Bees/Wasps | <input type="checkbox"/> Thimerosal/Mercury |
| <input type="checkbox"/> Formaldehyde | <input type="checkbox"/> 2-phenoxyethanol |
| <input type="checkbox"/> Aluminum | <input type="checkbox"/> Sulfa drugs |

MEDICATION ALLERGIES:

Please list any other medication allergies: _____

MEDICATIONS:

Please list all the medications/injections you are currently taking, including over-the-counter medications, and vitamins and minerals: _____

VACCINATION HISTORY:

Have you ever been vaccinated against or had any of the following diseases (*check all that apply*):

- | | | |
|---|---------------------------------------|---|
| <input type="checkbox"/> Measles | <input type="checkbox"/> Mumps | <input type="checkbox"/> Rubella ("German Measles") |
| <input type="checkbox"/> Varicella (Chickenpox or Shingles) | <input type="checkbox"/> Polio | <input type="checkbox"/> Hepatitis A |
| <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Tetanus | <input type="checkbox"/> Pertussis |
| <input type="checkbox"/> Meningitis | <input type="checkbox"/> Rabies | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Influenza | <input type="checkbox"/> Yellow Fever | <input type="checkbox"/> Japanese Encephalitis |
| <input type="checkbox"/> Typhoid | | |

Ever had a bad reaction to a vaccine? ☐ Yes ☐ No

If yes, please describe: _____

MEDICAL HISTORY:

Have you ever fainted from having your blood drawn or from an injection? ☐ Yes ☐ No

Do you have cancer, HIV/AIDS or any other immune disorder? ☐ Yes ☐ No

Have you taken steroids (Prednisone, Medrol) within the past 6 months? ☐ Yes ☐ No

Have you had any chemotherapy in the past 6 months? ☐ Yes ☐ No

Are you on Coumadin or warfarin? ☐ Yes ☐ No

Have you had or do you currently have any of the following:

- | | |
|---|--|
| -Fever in the last 48 hours | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| -Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| -Arrhythmia | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| -Low platelet count/coagulation disorder/prior or current severe anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| -Heart disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| -Kidney disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| -Hepatitis/liver disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| -Bipolar disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| -Depression/anxiety | <input type="checkbox"/> Yes <input type="checkbox"/> No |

-Other psychiatric problems O Yes O No
-Psoriasis O Yes O No
-Eye disease/condition O Yes O No
-G6PD deficiency O Yes O No
-Convulsions/seizures/epilepsy O Yes O No
-Asthma O Yes O No
-Diabetes O Yes O No

-Other: _____

FEMALE PATIENTS:

Are you pregnant? O Yes O No

Date of last menses: ____ / ____ / ____ or O Post-menopausal

Are you planning to become pregnant in the next year? O Yes O No O N/A

Are you breastfeeding? O Yes O No O N/A

Are you using birth control? O Yes O No

Method: _____

COMMENTS: