CAMPUS HEALTH TRAVEL CLINIC
THE UNIVERSITY of NORTH CAROLINA at CHAPEL HILL

Fee for Travel Services:
Student: $60
Non-Student: $75

This fee is not covered by insurance and will be charged to you upon submission of this questionnaire.

Name:	PID:	DOB:
Contact me by: UNC email:	OR	Phone:

Insurance (for meds/vaccines): ☐ RA/TA/Post Doc plan ☐ University Student plan
☐ Other, I will submit a copy of my medical and prescription card(s) with this form

I understand that my travel recommendations may contain personal health information.

☐ I prefer to receive all travel materials at my UNC email:

OR ☐ I prefer to pick up all travel materials on an USB drive at Campus Health Pharmacy.

Indicate your preferred day(s) and time slot(s) for your immunization appointment:
10am-12 noon: ☐ Mon. ☐ Thurs. **2:00pm-3:45pm:** ☐ Tues. ☐ Wed. ☐ Fri.

Please complete this form with a recent version of Acrobat Reader (ver. 10 or later). Sign and email to chstravel@unc.edu or bring it to Adm in.West (2nd floor of CHS) or fax to (919)966-6575. If you will visit more than 6 countries, please list on a 2nd travel questionnaire.

1. Travel Itinerary: List **ALL** countries you might visit **in order** of travel. An additional fee may apply **IF** substantial changes are made to your itinerary **AFTER** questionnaire submission. Include layovers **IF** in South America, Africa or Panama.

Arrival Date	**Country** (list **ALL** you may visit) **City or Region** in each country	**Departure Date** from Area

Return date to United States: Previous trips outside of U.S.:

Reason for Travel: ☐ Study abroad ☐ Medical/dental work with patient contact ☐ Vacation ☐ Conference ☐ Business
☐ Visit friends and family ☐ Other:

My travel is University-related. I've registered my trip at http://globaltravel.unc.edu. ☐ Yes ☐ No

2. Immunizations History (enter dates)

Covid-19: Brand: _____ (1) (2) (3)

Tetanus (last): Tdap ☐ Td ☐	Polio (last): Japanese Encephalitis:
MMR: (1) (2)	Meningococcal (MenACWY): Rabies (≥3 doses):
Hepatitis B: (1) (2) (3)	Varicella:(1) (2) 0 Had Chickenpox ☐ Typhoid injection (last):
Hepatitis A: (1) (2)	Pneumococcal 23-valent: Typhoid Oral caps (last):
Hep A&B: (1) (2) (3)	Influenza (last): Yellow Fever (last):

3. Risk Assessment: Please check all that apply. ☐ Work with animals ☐ Visit/work near swamps, rice or pig farms ☐ Rural areas ☐ Urban areas **ONLY** ☐ Camp/hike/bike ☐ Stay with local family ☐ High altitude (Over 8,000 ft./2,500 m) If so, trekking: ☐ Y ☐ N ☐ Scuba diving ☐ Spelunking/caving ☐ Extensive freshwater (not saltwater) exposure such as water sports or research/work related

My accommodations are: ☐ Hotels with air-conditioning ☐ Hostels with screening ☐ Local housing/apartment ☐ Tent ☐ Unknown/varied

4. Medical Conditions. Completion required.

Positive TB skin test	Y ☐ N ☐	Severe Headaches	Y ☐ N ☐	Blood clotting disorder or ever had a DVT or PE	Y ☐ N ☐
Heart problems	Y ☐ N ☐	Pregnant/breastfeeding	Y ☐ N ☐	Any thymus disorders: myasthenia gravis, DiGeorge syndrome, thymoma	Y ☐ N ☐
Seizure disorder	Y ☐ N ☐	Sickle cell anemia	Y ☐ N ☐	Have you been tested for G6PD deficiency If so, please check if positive or negative	Y ☐ N ☐ Pos ☐ Neg ☐
Psoriasis	Y ☐ N ☐	Sickle cell trait	Y ☐ N ☐	Severely allergic (anaphylaxis) to latex	Y ☐ N ☐
History of tendon rupture	Y ☐ N ☐	Splenectomy	Y ☐ N ☐	Severely allergic (anaphylaxis) to eggs	Y ☐ N ☐
Asthma	Y ☐ N ☐	Diabetes	Y ☐ N ☐	Carry Epinephrine - EpiPen or Auvi-Q	Y ☐ N ☐
Psychiatric disorder	Y ☐ N ☐	Immune deficiency/cancer	Y ☐ N ☐		

5. Medical Condition(s) not listed above: None ☐

6. Medications (including antacids/Prilosec): None ☐

7. Allergies & Reaction to meds, vaccines, food, insects: None ☐

For chronic medical conditions, I will check with my physician to discuss my care during travel, how to handle a worsening of symptoms, and if I should avoid specific vaccine(s). I read the CDC recommendations for my itinerary and relevant topics at cdc.gov/travel and CDC Traveler Information Center. **Signature:** **Date:**