

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:
Mailing Address:	8	Phone:
Insurance (for meds/vaccines): <input type="checkbox"/> RA/TA/Post Doc plan <input type="checkbox"/> University Student plan <input type="checkbox"/> 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. <input type="checkbox"/> I prefer to receive all travel materials at my UNC email: _____ OR <input type="checkbox"/> 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: 9:30am-11:30am: <input type="checkbox"/> Mon. <input type="checkbox"/> Thurs. 2:00pm-3:45pm: <input type="checkbox"/> Tues. <input type="checkbox"/> Wed. <input type="checkbox"/> Fri.		

Please complete this form with a recent version of Acrobat Reader (ver. 10 or later). Sign and email to travelclinic@unc.edu or bring it to Campus Health Pharmacy (basement of Campus Health) or fax to (919)966-6431. 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 you have received and dates. Completion required. Attachments allowed.

Tetanus (last): Tdap <input type="checkbox"/> Td <input type="checkbox"/>	Polio (last):	Japanese Encephalitis:
MMR: (1) _____ (2) _____	Meningococcal (MenACWY):	Rabies (≥3 doses):
Hepatitis B: (1) _____ (2) _____ (3) _____	Varicella:(1) _____ (2) _____ Had Chickenpox <input type="checkbox"/>	Typhoid injection (last):
Hepatitis A: (1) _____ (2) _____	Pneumococcal Adult Dose:	Typhoid Oral caps (last):
COVID Vax last dose:	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 <input type="checkbox"/> N <input type="checkbox"/>	Severe Headaches	Y <input type="checkbox"/> N <input type="checkbox"/>	Blood clotting disorder or ever had a DVT or PE	Y <input type="checkbox"/> N <input type="checkbox"/>
Heart problems	Y <input type="checkbox"/> N <input type="checkbox"/>	Pregnant/breastfeeding	Y <input type="checkbox"/> N <input type="checkbox"/>	Any thymus disorders: myasthenia gravis, DiGeorge syndrome, thymoma	Y <input type="checkbox"/> N <input type="checkbox"/>
Seizure disorder	Y <input type="checkbox"/> N <input type="checkbox"/>	Sickle cell anem	Y <input type="checkbox"/> N <input type="checkbox"/>	Have you been tested for G6PD deficiency If so, please check if positive or negative	Y <input type="checkbox"/> N <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/>
Psoriasis	Y <input type="checkbox"/> N <input type="checkbox"/>	Sickle cell trait	Y <input type="checkbox"/> N <input type="checkbox"/>	Severely allergic (anaphylaxis) to latex	Y <input type="checkbox"/> N <input type="checkbox"/>
History of tendon rupture	Y <input type="checkbox"/> N <input type="checkbox"/>	Splenectomy	Y <input type="checkbox"/> N <input type="checkbox"/>	Severely allergic (anaphylaxis) to eggs	Y <input type="checkbox"/> N <input type="checkbox"/>
Asthma	Y <input type="checkbox"/> N <input type="checkbox"/>	Diabetes	Y <input type="checkbox"/> N <input type="checkbox"/>	Carry Epinephrine - EpiPen or Auvi-Q	Y <input type="checkbox"/> N <input type="checkbox"/>
Psychiatric disorder	Y <input type="checkbox"/> N <input type="checkbox"/>	Immune deficiency/cancer	Y <input type="checkbox"/> N <input type="checkbox"/>		

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:** _____