A $25 yellow fever vaccine assessment charge will be billed to you upon submission of this questionnaire.
This charge is in addition to the $200 charge for the yellow fever vaccine

YELLOW FEVER VACCINE QUESTIONNAIRE

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

Name: _____PID:_____ Date of Birth_____
Mailing Address_____
Email _____ or Phone_____
Preferred method of communication ☐ Email ☐ Phone

Include a copy of your insurance card with this questionnaire.

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. Sign and bring to Campus Health Pharmacy or Student Stores Pharmacy or email to travelclinic@unc.edu or fax to: 919-966-6431. If you will possibly visit more than 6 countries, please list on a 2nd Yellow Fever Vaccine Questionnaire.

1. **Travel Itinerary**: List ALL countries **in order** of travel. Include layovers in countries of South America, Africa or in Panama.

Arrival Date	Country	City, Region, or Area	Departure Date from Area

Return date to United States:

2. Have you ever received a yellow fever vaccine? ☐ Yes ☐ No

If yes, date of last yellow fever vaccine

3. Check which of the below vaccines you have received in the last 30 days, or that you plan to receive in the next 60 days:

☐ MMR ☐ Varicella (chicken pox) ☐ Zoster (shingles) vaccine ☐ Intranasal influenza vaccine

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

5. Medical Conditions. Completion required.

Pregnant	☐ Y	☐ N	Breastfeeding	☐ Y	☐ N
HIV Infection	☐ Y	☐ N	Radiation Therapy	☐ Y	☐ N
Immune Deficiency/Cancer	☐ Y	☐ N	Organ Transplant	☐ Y	☐ N
Any thymus disorder: myasthenia gravis, DiGeorge syndrome, thymoma, thymectomy	☐ Y	☐ N	Severe Allergy to eggs	☐ Y	☐ N

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

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

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

I understand that this request is for yellow fever vaccine only, and that I should seek out full travel clinic services for a complete set of recommendations for my trip, including malaria prophylaxis medication and other vaccines that might be indicated. I have opted not to use the Campus Health Services International Travel Clinic at this time for a full set of recommendations.

Signature **Date**