Penn State University Health Services – Travel Clinic Information

Travel Information Resources:
We are relying on you to read specific information about your destination and steps to take to remain healthy while you travel. Please review the websites below to become familiar with your destination, traveler’s health topics, and additional information for your return home. The CDC’s Health Information for International Travel ("Yellow Book") is a valuable resource on health information for the international traveler and can be viewed online https://wwwnc.cdc.gov/travel.page/yellowbook-home.

Centre for Disease Control https://wwnc.cdc.gov/travel
Shoreland Travel Services https://tripprep.com
Malaria https://www.cdc.gov/parasites/malaria/index.html
Yellow Fever Vaccination https://www.cdc.gov/yellowfever/index.html
Vaccine Information Statements https://www.immunize.org/vaccines/vis/about-vis/
U.S. Department of State https://www.travel.state.gov

Traveler’s Insurance Plan:
http://studentaffairs.psu.edu/health/services/insurance/educationAbroad.shtml Other
Travel Medical Insurance Options:
https://travel.state.gov/content/passports/en/go/health/insurance-providers.html

Those scheduled to travel are encouraged to use the Global Safety - Penn State Travel Safety Network: https://gsn.psu.edu/login

Prior to Your Travel Appointment at UHS:
1. Complete the Pre-Travel Health Consultation and History Form.
2. Obtain a copy of your immunization records from birth to present, including any blood/titer tests
   –PSU Student may have submitted their immunization history to UHS at the time at admittance.
   Students can log into MyUHS and verify that UHS has their immunization records at:
   http://www.studentaffairs.psu.edu/health/myUHS/login.shtml
   For information on locating your immunization/vaccine records go to:
   https://www.cdc.gov/vaccines/adults/vaccination-records.html
3. Fax or drop off your completed form and immunization records not already on file with UHS.
   Upon receipt, your travel appointment will be scheduled.

Day of Your Appointment:
1. Please arrive 15 minutes prior to your scheduled appointment time and check in with a receptionist. Your appointment may take up to 60 minutes, and you will be required to wait 15 minutes after vaccinations are administered.
2. Please be sure that you have had something to eat and drink prior to your appointment.
3. For female patients: If your menstrual period is delayed, you may be asked to provide a urine sample for pregnancy screening prior to the administration or prescribing of any needed vaccines/medication.

**Promptly notify the UHS Travel Clinic of any changes or additions in your medical history or trip itinerary by fax at 814-86-2584, "Attention Travel Clinic", or by calling University Health Services at 814-865-4847, option 3.

The Travel Clinic utilizes TRAVAX, a computer software program which is updated weekly with information from the CDC, ACIP, AAP, and WHO, as well as ongoing global surveillance and published literature.
PRE-TRAVEL HEALTH CONSULTATION AND HISTORY FORM

Complete this form and FAX TO 814-865-6982 OR DROP OFF at UHS along with all immunization records. Upon receipt of your completed form and immunization records, your appointment will be scheduled.

Today’s Date: __________________________

Name: ___________________________ DOB: ___________________________ PSU ID#: ___________________________

Legal Sex: □ Male  □ Female □ Non-Binary  Sex at Birth: ___________________________ Pronouns: ___________________________

Home Phone: ___________________________ Work Phone: ___________________________ Mobile Phone: ___________________________

Home Address: __________________________________________________________

City: ___________________________ State: ________ Zip: __________ Email: ___________________________

Country of Birth: ___________________________ Citizenship: ___________________________

Occupation: __________________________________________________________

Primary care physician’s name: __________________________________________

Primary care physician’s address: __________________________________________ Phone: ___________________________

TRAVEL PLANS (list additional information on back of form if needed):

Date of Departure for Destination: ___________________________ Return Date/Length of Trip: ___________________________

Have you traveled internationally in the past? □ Yes □ No  If yes, where?: ___________________________

Do you intend to travel frequently in the future? □ Yes □ No

Countries and cities in order of visit (list all, including stopovers)  Arrival Date  Departure Date

1.  

2.  

3.  

4.  

5.  

6.  

Is your itinerary fixed? □ Yes □ No  □ Not sure

Destination: □ Rural  □ Urban  □ Remote  □ High Altitude (8,000ft/2500m or higher) □ Beach

Purpose of trip (check all that apply)

□ Vacation  □ Education/research  □ Adoption  □ Visit friends or family  □ Missionary/volunteer/humanitarian relief

□ Work/Business  □ Medical/Dental care  □ Pilgrimage  □ Long-stay traveler  □ Other ___________________________

Organized tour? □ Yes □ No  □ Party  Explain: ___________________________

Accommodations? □ Hotel  □ Hostel  □ Staying with locals/family/friends  □ Dorm  □ Camping

□ Cruise ship/Boat  □ Rented house/apartment  □ Availability of bed nets
## PRE-TRAVEL HEALTH CONSULTATION AND HISTORY FORM

**Patient Name:**  
**DOB:**  

### HEALTH HISTORY

- **Will you be traveling alone?**  
  - [ ] Yes  
  - [ ] No  
  If no, explain: ____________________________________________

- **Do you plan to rent a car?**  
  - [ ] Yes  
  - [ ] No

**Planned activities:**  
- [ ] Air travel  
- [ ] Biking  
- [ ] Hiking  
- [ ] Swimming  
- [ ] Rafting  
- [ ] Boating  
- [ ] Scuba  
- [ ] Climbing/Trekking  
- [ ] Contact with animals  
- [ ] Caves/Spelunking  
- [ ] Public transport (bus, train, etc.)  
- [ ] Snorkeling  
- [ ] Visiting schools/hospitals or orphanages  
- [ ] Medical/dental work  
- [ ] Other: __________________________

- **Have you obtained travel medical evacuation insurance?**  
  - [ ] Yes  
  - [ ] No

### PRE-TRAVEL HEALTH CONSULTATION AND HISTORY FORM

- **Do you have any chronic health problems for which you take medication on a regular basis or see a health care provider?**  
  - [ ] Yes  
  - [ ] No  
  If yes, explain: ____________________________________________

- **Are you currently under the care of a physician for any health problem?**  
  - [ ] Yes  
  - [ ] No  
  If yes, explain: ____________________________________________

- **When was your last dental visit?**  
  ________________________________

- **Do you smoke, vape, or use recreational drugs?**  
  - [ ] Yes  
  - [ ] No  
  If yes, explain: ____________________________________________

- **Do you drink alcohol regularly?**  
  - [ ] Yes  
  - [ ] No  
  If yes, explain: ____________________________________________

- **Have you ever taken undesirable risks or had an adverse reaction to the use of alcohol?**  
  - [ ] Yes  
  - [ ] No  
  If yes, explain: ____________________________________________

- **List any surgeries you have had in the past 5 years:**  
  ________________________________

### Check all that apply:

- **Allergies**  
  - [ ] Anaphylactic reaction (severe allergic reaction)  
  - [ ] Antibiotics (e.g., penicillin, sulfa)  
  - [ ] Other medications: ____________________________
  - [ ] Latex  
  - [ ] Egg  
  - [ ] Gelatin  
  - [ ] Yeast  
  - [ ] Other Food Allergy: ____________________________
  - [ ] Bees/wasps  
  - [ ] Animals  
  - [ ] Seasonal/Environmental  
  - [ ] Vaccine  
  - [ ] Other: ____________________________

- **Side effects/reactions** from previous medications (e.g., nausea, dizziness, stomach upset): ____________________________

- **Cancers/blood disorder**  
  - [ ] Coagulation disorder  
  - [ ] History of cancer or blood disorder  
  - [ ] Blood transfusion within the past 5 years  
  - [ ] Other: ____________________________

### Skin

- [ ] Psoriasis
- [ ] Other:

### Endocrine

- [ ] Diabetes
- [ ] Thyroid disease
- [ ] Other:

### Cardiovascular

- [ ] Arrhythmia (rhythm disturbance considered significantly abnormal including atrial fibrillation, heart block)
- [ ] Implanted pacemaker or automatic defibrillator
- [ ] Heart attack
- [ ] High cholesterol
- [ ] High blood pressure
- [ ] Stroke
- [ ] Other:

### GI

- [ ] Crohn’s disease or ulcerative colitis
- [ ] IBS
- [ ] GERD
- [ ] Chronic hepatitis
- [ ] Cirrhosis or liver failure
- [ ] Other:

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# PRE-TRAVEL HEALTH CONSULTATION AND HISTORY FORM

## Kidneys
- Dialysis
- Kidney insufficiency
- Other: ________________________________

## Lungs
- Asthma
- Emphysema/COPD
- High Altitude Sickness
- Prior TB Testing
- Other: ________________________________

## Immune system
- Steroids by mouth within last 3 months
- Allergy immunotherapy
  - Date of last allergy injection: _______________
- Immune suppressive medications or treatments within last 3 months (e.g., radiation, cancer chemotherapy drugs, methotrexate, azathioprine, adalimumab, anakinra, etanercept, infliximab, leflunomide, rituximab)
- Spleen removed
- G6PD Deficiency
- Myasthenia Gravis/DiGeorge Syndrome
- Thymus disease or thymectomy
- HIV/AIDS
  - Most recent CD4: __________________
  - Most recent viral load: ________________
- Organ, bone marrow, stem cell transplant
- Other: ________________________________

## Musculoskeletal
- Rheumatoid arthritis
- Psoriatic arthritis
- Tendonitis/Achilles heel rupture
- Other: ________________________________

## Neurologic/psychiatric
- Seizures or epilepsy
- Anxiety/depression
- History of Guillain-Barré
- Disordered Eating
- Other: ________________________________

## Obstetrics/Gynecology
- When was your last menstrual periods (LMP)? __________
- Was your last LMP normal? ☐ Yes ☐ No
  - If no, explain: ________________________________
- Are you currently pregnant, trying to get pregnant, or planning a pregnancy in the near future? ☐ Yes ☐ No
- Any risk of unplanned pregnancy? ☐ Yes ☐ No
- Are you breastfeeding? ☐ Yes ☐ No
- What form of contraception do you use? _______________

## Vaccination History:
- Have you received a dose of the COVID-19 vaccine in the past 8 weeks? ☐ Yes ☐ No
- Have you had a positive COVID-19 test or been diagnosed with COVID-19 in the past 3 months? ☐ Yes ☐ No
- Have you received a dose of Mpox vaccine in the last 4 weeks? ☐ Yes ☐ No

## CURRENT MEDICATIONS

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<th>Medication</th>
<th>Reason for use/medical condition</th>
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## PRE-TRAVEL HEALTH CONSULTATION AND HISTORY FORM

### Non-prescription products: List current over-the-counter, herbal, homeopathic products, vitamins, supplements, etc.

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<th>Product</th>
<th>Reason for use/medical condition</th>
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Please tell us any additional information about your health history that you believe is important for us to know as you prepare for your trip, including any concerns or fears?

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I have answered this questionnaire fully and to the best of my ability.

Patient/Traveler’s Signature: ________________________________ Date: ______________________

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Office use only

Healthcare Provider’s Signature/Credentials: ________________________________

Date Reviewed: ________________
Penn State University Health Services – Travel Clinic

Charges and Billing

Please review and complete:

UHS offers travel appointments for students, eligible dependents, and eligible faculty and staff. Faculty, staff, and dependent students will be charged a $70 consultation fee. You may also incur fees for laboratory tests and travel prescriptions. Payment will be due on the day of the visit. Patients interested in Yellow Fever or Typhoid vaccines will also be required to pay at the time of service. Yellow fever is $200 and Typhoid is $246. UHS accepts debit/credit card and health savings account payments only.

Any additional vaccines will be billed to your insurance. It is your responsibility to contact your insurance company to understand your coverage. Insurance information will be collected prior to your visit.

A “No Show” or late cancellation fee will be changed for missed travel clinic appointments or appointments not cancelled at least 24 hours prior to the appointment date/time.

If your college/department is paying for any charges associated with your travel visit, to ensure proper billing for your services, please fill out the information below. Anything not covered by your department or health insurance will be your responsibility.

Is a Penn State college/department paying for your travel clinic charges? _____YES _____ NO

If yes, to ensure proper billing for your services, please complete the information below.

Penn State College/Department Name: _________________________________________________________________

Name of College/Department Contact Person: __________________________________________________________

Campus Address for Contact Person: __________________________________________________________________

Phone Number/Email Address of Contact Person: ______________________________________________________

PRINTED NAME OF TRAVEL CLINIC PATIENT

________________________________________________________  ____________________________
Patient Signature                                      Date

PSU ID#/DOB

Form Distribution:
Financial Services
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