

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://wwwnc.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	www.travel.state.gov
U.S. Department of State-Bureau of Consular Affairs	https://travel.state.gov/content/travel/en/international-travel/before-you-go/step.html
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://qsn.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.



(Affix Patient Label Here)
Patient Name:
DOB:

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

Table with 3 columns: Countries and cities in order of visit (list all, including stopovers), Arrival Date, Departure Date. Rows 1-6.

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



(Affix Patient Label Here)

Patient Name: _____

DOB: _____

PRE-TRAVEL HEALTH CONSULTATION AND HISTORY FORM

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

HEALTH HISTORY

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

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: _____



(Affix Patient Label Here)

Patient Name: _____

DOB: _____

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	
Prescription medications: List all current prescription medications	
Medication	Reason for use/medical condition

(Affix Patient Label Here)

Patient Name: _____

DOB: _____

PRE-TRAVEL HEALTH CONSULTATION AND HISTORY FORM

Non-prescription products: List current over-the-counter, herbal, homeopathic products, vitamins, supplements, etc.	
Product	Reason for use/medical condition

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?

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

Patient/Traveler's Signature: _____ Date: _____

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 charged 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

308 Student Health Center

3/15/2024

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