CMU HEALTH
CENTRAL MICHIGAN UNIVERSITY

Travel Health Clinic

Process

1. Obtain Forms
   - Pick up at 200 Foust Hall, located at 600 E. Preston, Mt. Pleasant, MI
     OR
   - Print from our clinic website at www.cmuhealth.org
     - Click on **Specialty Care**
     → Travel Medicine
     → Link to **Travel Health Clinic Forms** is found under the Study Abroad header.
2. Submit Completed forms
   - Drop off or mail to: CMU Health Services, 200 Foust Hall, 600 E. Preston, Mt. Pleasant, MI 48859
     OR
   - Fax to us at (989) 774-4335
     OR
   - Email to us at travelhealth@cmich.edu
3. Get Appointment
   - After you submit your forms, one of our Travel Health Clinic staff will contact you to schedule an appointment after a packet of information has been assembled for your area of travel. **This may take 1-2 weeks**.
4. Billing of Services
   - The Travel Health Visit includes a brief visit with one of our physicians, a review of your itinerary, personal health history, immunization status and development of recommendations specific to your needs.
   - An office visit charge, along with immunization charges, (if any), will be billed:
     A) Directly to the patient (self-pay); or
     B) To patient's insurance (subject to copay, coinsurance, and/or deductible)
     Patients who choose Option A, the self-pay option, may qualify for a 30% discount.

Please let staff know how you would like the visit charges billed **at time of appointment check-in.**
Once/if insurance is billed, the 30% discount cannot be applied.

Important: Please note, some health insurance plans do not cover preventive services, including immunizations for any reason including travel. It is the patient's responsibility to contact their insurance company with questions about coverage for this and any other service. The patient is responsible for all visit charges.

Travel Health appointments are limited in number, so we ask that you notify us at least 24 hours in advance if you cannot keep your scheduled appointment so other patients may schedule appointments.

To cancel or reschedule, call our Appointment Desk at (989) 774-6599, option #1.

If you have any questions, or need additional information, please do not hesitate to contact us at (989) 774-6599, option #2. We look forward to assisting you with safe travel!

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Patient Registration

This information is confidential and will be used only to prepare recommendations specific to your personal travel health needs.

Patient's Name (Last, First, Middle) Campus ID #

Local Address (Street) Apt/Rm # City State Zip

Age Date of Birth Sex Local Phone #

Email: _____ Leave Date: _____ Return Date: _____

Travel Information

Please indicate all the countries to which you will be traveling in the order in which you will visit them and indicate the length of time you will stay in each country. Add additional pages if necessary.

	Destination	Where will you stay?	Length of stay	Rural/Urban
1				
2				
3				
4				
5				

Please check all that apply to your travel plans.

Major resort hotels		Cruise Ship		Camping		Outdoor activities	
Staying with a family		Small Hotels		Safari		Animal Exposure	
Rented foreign home		Youth hostels		Rural travel at any time		Other	

What is the purpose of your trip? Check all that apply.

Business		Study		Vacation		Missionary	
Teaching		Volunteer Agency		Field Work		Climbing	
Diving		Other					

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Please PRINT Clearly

Health History

Name: _____ Date of Birth: _____
Last, First, Middle (please print)

Circle Answer

1. Do you have any medication/food/exposure allergies? If yes, please list below: No Yes

Allergic to:	Type of Reaction:

2. Have you ever had an adverse reaction to an immunization? No Yes
   If yes, which immunization and what type of reaction?
   _____
3. Are you now or have you ever been treated for leukemia, lymphoma, cancer, other malignant disease or immune deficiency? If yes, please specify: No Yes
   _____
4. Do you currently live with anyone who has an immune deficiency? No Yes
5. Do you have a history of anemia or any other blood disorder? No Yes
   If yes, please specify: _____
6. Do you have any existing medication condition, e.g., diabetes, heart disease, asthma, neurological or psychological history? No Yes
   If yes, please specify: _____
7. Have you had any surgeries? No Yes
   If yes, please specify: _____
8. Are you pregnant or do you plan to become pregnant in the next 3 months? No Yes
9. Are there any other health concerns you have related to your travel plans? No Yes
   If yes, please specify: _____
10. Please list all medications (prescription and over the counter). Include any vitamins, minerals, herbs, or other supplements that you take regularly.

Medication	Dosage	Frequency

Add additional sheets if necessary.

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Immunization History

Name: _____ Date of Birth:_____
Last, First, Middle (Please print.)

Include your childhood immunizations on this form. If you had the disease rather than the vaccine (e.g., a case of the chickenpox rather than receiving varicella vaccine), please include the actual or approximate dates.

Immunization/Disease	Disease Date	Immunization Dates			
1. Tetanus/diphtheria (Td) _____					
Tetanus/diphtheria/pertussis (Tdap) _____ *(one time booster)*					
2. Measles/mumps/rubella (MMR)*		#1	#2		
3. Polio: Oral (OPV) ___ Injectable (IPV) ___					
4. Varicella (chickenpox)		#1	#2		
5. Hepatitis B		#1	#2	#3	
6. Meningococcal Meningitis: Menveo™ ___ Menactra ™ ___					
7. Influenza (flu)					
8. Hepatitis A		#1	#2		
9. Immune Globulin					
10. Japanese Encephalitis					
11. Plague					
12. Pneumonia (Pneumovax™)					
13. Rabies					
14. Typhoid: Oral Injectable ___					
15. Yellow Fever					
16. BCG					
17. TB (Mantoux PPD skin test)					
18. Other (specify)					
***If MMR not received, specify individual vaccines/diseases.**					
Measles (rubeola)					
Mumps					
Rubella (German measles)					

Patient Signature:_____**Date:** _____

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Student Health Services
600 E. Preston St., Foust 200
Mt Pleasant, MI 48859
Phone: 989-774-6599 Fax: 989-774-4335

Patient Information Form

Full Legal Name: _____ Preferred Name:_____ DOB:_____

Email: _____ Phone:_____ CMU ID# _____

Billing Address: _____

City, State, Zip: _____

Sex Assigned at Birth: ❑ Male ❑ Female **Gender Identity**: ❑ Male ❑ Female ❑ Non-Binary ❑ Other

Preferred Pronouns: She/Her/Hers He/Him/His They/Them Other: _____

INSURANCE INFORMATION

REQUIRED: 1. Card/Policy Holder info below – this may not be the same as Patient
2. A copy of insurance card(s) both front and back

Patient's Relationship to Policyholder: ❑Self ❑Child ❑Spouse ❑ Other: _____

Cardholder Name: _____

Date of Birth: _____ Phone: _____

Insurance Company Name & Address:

_____

_____

Policy #: _____

Group #: _____

Examples of participating and non-participating insurances below:

PARTICIPATING

Blue Cross of MI and Out of State
Aetna
United Healthcare
Priority Health
Michigan Medicaid
McLaren Health Advantage

NON-PARTICIPATING

Cigna
Out of State Medicaid
BCN (will cover with authorization from PCP)
HAP (may cover with authorization from HAP)

All patients are subject to their insurance policy plans and provisions such as deductible and copay.
It is the responsibility of the patient to contact their insurance regarding coverage at CMU Health Services.