**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 FAQ regarding Study Abroad
1. 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 healthservices@cmich.edu
1. Get Appointment
* After you submit your forms, one of our Travel Health Clinic nurses 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**.
1. 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:
1. Directly to the patient (self-pay); or
2. 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 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!

**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 travel? Check all that apply.**

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

**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: |
|  |  |
|  |  |
|  |  |

1. Have you ever had an adverse reaction to an immunization? No Yes

If yes, which immunization and what type of reaction?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Are you now or have you ever been treated for leukemia, lymphoma, cancer, other No Yes malignant disease or immune deficiency? If yes, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Do you currently live with anyone who has an immune deficiency? No Yes
3. Do you have a history of anemia or any other blood disorder? No Yes

If yes, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you have any existing medication condition, e.g., diabetes, heart disease, asthma, No Yes neurological or psychological history?

If yes, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you had any surgeries? No Yes

If yes, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Are you pregnant or do you plan to become pregnant in the next 3 months? No Yes
2. Are there any other health concerns you have related to your travel plans? No Yes

If yes, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. 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

**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:Menomune™ Menactra ™  |  |  |  |  |  |
| 7. Influenza (flu) |  |  |  |  |  |
| 8. Hepatitis A |  | #1 | #2 |  |  |
| 9. Immune Globulin |  |  |  |  |  |
| 10. Japanese Encephalitis |  |  |  |  |  |
| 11. Plague |  |  |  |  |  |
| 12. Pneumonia (Pneumovax™) |  |  |  |  |  |
| 13. Rabies |  |  |  |  |  |
| 14. Typhoid:OralInjectable  |  |  |  |  |  |
| 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**