Texas Children's Hospital
Changing the face of healthcare, one child at a time.®

Travel Medicine Clinic

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Baylor College of Medicine
GIVING LIFE TO POSSIBLE

Please complete and return via fax or email

Patient Name: _____ Phone: _____

Date of Birth: _____ Age: _____ Gender: ☐ Male ☐ Female

Patient Email: _____

Pharmacy Name: _____ Phone: _____

Pharmacy Address: _____

Emergency Notification:

Name: _____ Phone: _____

Email: _____ Relationship: _____

Referral Source:

☐ Self ☐ Physician ☐ Employer ☐ Other

Travel Information (Fill in COMPLETELY):

Departure Date: _____ Total Length of Trip: _____

Is this a fixed itinerary? ☐ Yes ☐ No ☐ Unsure

Please list in chronological order the cities and countries you are scheduled to visit. Be as specific as possible. This information is helpful in determining your health risks.

Country	City	Arrival Date	Departure Date	Area Type
_____	_____	_____	_____	☐ Urban ☐ Rural ☐ Transit or lay-over only
_____	_____	_____	_____	☐ Urban ☐ Rural ☐ Transit or lay-over only
_____	_____	_____	_____	☐ Urban ☐ Rural ☐ Transit or lay-over only
_____	_____	_____	_____	☐ Urban ☐ Rural ☐ Transit or lay-over only
_____	_____	_____	_____	☐Urban ☐ Rural ☐ Transit or lay-over only
_____	_____	_____	_____	☐Urban ☐ Rural ☐ Transit or lay-over only

What is the purpose of your travel? (Check all that apply)

☐ Business ☐ Relocation ☐ Missionary/Volunteer ☐ Healthcare Worker

☐ Vacation ☐ Study/Teaching ☐ Visiting Friends/Relatives ☐ Adoption

☐ Peace Corps ☐ Organized Tour ☐ To obtain Medical or Dental care

☐ Occupational Exposure to animals or insects ☐ Other _____

Activities:
What activities do you have planned? (Check all that apply)

☐ Hiking ☐ Climbing ☐ Rafting ☐ Caving/Spelunking

☐ Safari ☐ Scuba Diving ☐ Biking or Running ☐ Animal Contact

☐ Construction ☐ Other _____

Will you be ascending to high altitudes (above 8000 feet)? ☐ Yes ☐ No ☐ Unsure

Accommodations:
Where will you be staying? (Check all that apply)

☐ Hotel/Resort ☐ Camp/Tent ☐ Cruise ship ☐ Compound

☐ Private home ☐ Upscale Camping Lodge ☐ Other _____

Will any accommodations NOT have air conditioning? ☐ Yes ☐ No

Will you be staying or eating with local families? ☐ Yes ☐ No

Will your travel include rural areas? ☐ Yes ☐ No

Medical History:
Are you being treated for any medical conditions: ☐ Yes ☐ No

Please explain any "Yes" answers: _____

_____

Medications (Please list all prescribed, over-the-counter medication and supplements you use):

Medication/Supplement	Reason for Use

Do you have any of the following conditions? Please Check "Yes" or "No"

Seizures/Epilepsy	☐ Yes	☐ No	Cancer	☐ Yes	☐ No
Nightmares/Night Terrors	☐ Yes	☐ No	HIV Infection	☐ Yes	☐ No
Depression/Psychiatric Disorder	☐ Yes	☐ No	Immune Disorder/Autoimmune	☐ Yes	☐ No
G6PD Deficiency	☐ Yes	☐ No	Psoriasis	☐ Yes	☐ No
Hemophilia	☐ Yes	☐ No	Arrhythmia (irregular heartbeat)	☐ Yes	☐ No
Sickle Cell	☐ Yes	☐ No	Guillan Barre Syndrome	☐ Yes	☐ No
Stomach/Intestinal Problems	☐ Yes	☐ No	Myasthenia Gravis	☐ Yes	☐ No
Motion Sickness	☐ Yes	☐ No	History of Altitude Sickness	☐ Yes	☐ No

Please explain any "Yes" answers: _____

_____

Are you currently taking immune modulating medications? ☐ Yes ☐ No

If yes, please list: _____

Are you currently taking prednisone, cortisone or some other steroid? ☐ Yes ☐ No

Have you received blood products or immune globulin in the past 12 months? ☐ Yes ☐ No

Are you pregnant, planning to be pregnant or breastfeeding? ☐ Yes ☐ No

Allergies:

Medications	☐ Yes	☐ No	If yes, list: _____
Egg or other food allergies	☐ Yes	☐ No	If yes, list: _____
Environmental (pollens, dust, hay fever)	☐ Yes	☐ No	If yes, list: _____
Animals	☐ Yes	☐ No	If yes, list: _____
Bee Stings	☐ Yes	☐ No	If yes, list: _____

Have you ever experienced anaphylaxis (severe allergic reaction)? ☐ Yes ☐ No

If yes, please explain: _____

Have you ever required an Epi-Pen? ☐ Yes ☐ No

If yes, please explain: _____

Immunization History:

Have you ever had a reaction to vaccine? ☐ Yes ☐ No

If yes, please explain: _____

Have you received any vaccines in the last 4 weeks? ☐ Yes ☐ No

If yes, please list: _____

Have you ever received any vaccines for travel? ☐ Yes ☐ No

List the dates of your vaccines. Otherwise, check “Had Disease” or “Unknown”. If you have your immunization records, you may attach them instead of completing this form.

	Vaccine Dates				
	#1	#2	#3	Had Disease	Unknown
Hepatitis A	_____	_____	_____	☐	☐
Hepatitis B	_____	_____	_____	☐	☐
Measles, Mumps, Rubella (MMR)	_____	_____	_____	☐	☐
Polio	_____	_____	_____	☐	☐
Tetanus (Td or Tdap)	_____	_____	_____	☐	☐
Varicella (chicken pox)	_____	_____	_____	☐	☐
Meningococcus (meningitis)	_____	_____	_____	☐	☐
Pneumococcus (pneumonia)	_____	_____	_____	☐	☐
Influenza	_____	_____	_____	☐	☐
Typhoid (Oral)	_____	_____	_____	☐	☐
Typhoid (injection)	_____	_____	_____	☐	☐
Japanese Encephalitis	_____	_____	_____	☐	☐
Yellow Fever	_____	_____	_____	☐	☐
Rabies	_____	_____	_____	☐	☐

Please check to make sure you have answered ALL questions. Incomplete forms may delay scheduling.

Please sign and date:

Signature: _____ Date: _____