MARQUETTE UNIVERSITY
Medical Clinic

Name:_____
MUID: _____

Travel Clinic Information

Today's Date: _____ Departure Date: _____ Return Date: _____

Previous travel to: _____

Previous Malaria medication: _____ Side Effects: _____

Itinerary

List all countries, cities, and areas you will visit in order of travel. Please attach additional sheet if needed.

Country	Length of stay	Major City/Cities	Rural Areas # of days if malaria is concern

Primary purpose of trip: Study Abroad Tourism Healthcare work Volunteer Work

Plans include: Scuba diving High altitude (>8000ft/2500m.) Ship Travel Other _____

Lodging: Resort/Hotel House Tent Other _____

Are you currently enrolled in a health insurance plan that covers while overseas? YES NO

Do you have medical evacuation insurance? YES NO

Medical Problems (circle past or present): **NONE**

Heart disease/Abnormal Rhythm	Lung Disease	Kidney Disease	Liver Disease
Gastrointestinal Disease	Retina Disease (Eye)	Spleen Removed	Psoriasis
Seizures/Epilepsy	Psychiatric Illness	Neurologic Disorder	Myasthenia Gravis
Clotting/Bleeding Disorder	G6PD Deficiency		

Do you have any medical conditions that warrant maintenance medications or physician follow-ups? YES NO

Current Medications (including OTC, contraceptives, supplements) :

_____

Allergies: Medications _____ Foods_____ Insects/Beesting _____

Vaccines_____

Type of reaction: _____

MARQUETTE UNIVERSITY
Medical Clinic

Patient Name:_____
MUID: _____

Screening Questionnaire for Adult Immunization

1. Do you have documentation of having your routine childhood vaccination series? **YES** **NO**
2. Have you ever had a serious reaction to receiving a vaccine? **YES** **NO**
3. Do you have cancer, leukemia, AIDS, or any other immune system problems? **YES** **NO**
4. Do you take cortisone, prednisone, steroids, or anticancer drugs or have you had x-ray treatments? **YES** **NO**
5. Have you had a seizure or other nervous system problem? **YES** **NO**
6. During the last year have you received a transfusion of blood or blood products or been given a medicine called immune (gamma) gloubin? **YES** **NO**
7. *For Women*: Are you pregnant, breastfeeding or is there a chance you could become pregnant during the month following vaccination? **YES** **NO**
8. Have you received any vaccination in the last 4 weeks? **YES** **NO**
9. Have you ever fainted from having your blood drawn or from an injection? **YES** **NO**

Immunization History

Immunizations	Dates of Immunizations
Tetanus, TD, DPT, Tdap Last booster dose	1._____
Polio by injection or oral	1._____ 2._____ 3._____ 4._____
MMR	1._____ 2._____
Chicken Pox or **Varicella** (give dates of disease or vaccine)	1._____ 2._____ Date of disease:_____
Hepatitis A	1._____ 2._____
Hepatitis B series	1._____ 2. _____ 3._____
Meningitis	Menactra _____ Menomune _____
Typhoid	Injection _____ Oral _____
Yellow Fever	1._____
Rabies series	1._____ 2._____ 3._____ (pre-exposure)
Influenza	1._____
Japanese Encephalitis	1._____ 2._____
TB Test	Date: _____ Results: _____

I attest that the above information is true to the best of my knowledge.

_____
(Student signature)