TRAVEL HEALTH ASSESSMENT

Name:_____
First Middle Last

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

If child is a minor, Parent/Guardian Name:_____

Address:_____

City:_____ State:_____ Zip:_____ County:_____

Daytime Phone:_____ Other Phone:_____

Family Physician/Phone #:_____

Destination(s):_____ **Departure Date:** ____/____/____ **Length of Stay:**_____

Reason for Travel: _____ **Pleasure** _____ **Business** _____ **Mission** _____ **Other:**_____

RACE
- ☐ Am Indian/Alaskan Native
- ☐ Arabic
- ☐ Asian
- ☐ Black/African American
- ☐ Native Hawaiian/Pacific Islander
- ☐ White
- ☐ Other

ETHNICITY
- ☐ Hispanic/Latino
- ☐ Not Hispanic/Latino

HEALTH QUESTIONS

Are you well today?	____ Yes	____ No
Have you been ill recently?	____ Yes	____ No
Fever?	____ Yes	____ No
Have you had any shots in the past month? If YES, what:_____	____ Yes	____ No
Have you had any injection of immune globulin or other blood product in the past 8 months?	____ Yes	____ No
WOMEN: Are you pregnant or breastfeeding?	____ Yes	____ No

Please check the boxes if you have had any of the following conditions:

☐ Heart Problems	☐ High Blood Pressure	☐ Neurological Disease	☐ Stomach Problems
☐ Diabetes	☐ Kidney Disease	☐ Cancer	☐ Leukemia
☐ Lymphoma	☐ HIV/AIDS	☐ Lung Disease	☐ Liver Disease
☐ Eye Conditions	☐ Psoriasis	☐ Problems with Immune System	

Medications you are taking:_____

Do you have a history of seizures or convulsions?	____ Yes	____ No
Have you ever had hepatitis or yellow jaundice?	____ Yes	____ No
Have you ever fainted from having your blood drawn or from a shot?	____ Yes	____ No
Have you ever had a bad reaction to a vaccination?	____ Yes	____ No
Do you have a problem with nightmares?	____ Yes	____ No
Insomnia?	____ Yes	____ No
Do you have any bowel conditions, such as diarrhea or constipation?	____ Yes	____ No
Do you have medical or surgical conditions that need maintenance medications for which you have to see a physician regularly?	____ Yes	____ No
Have you had any medical conditions that are stable now, but which may recur while traveling?	____ Yes	____ No
Do you have severe thrombocytopenia (low blood platelet count) or a blood disorder?	____ Yes	____ No
Have you had your spleen removed?	____ Yes	____ No

Allergies (please check if you are allergic to any of the following)

☐ Eggs	☐ Gelatin	☐ Yeast	☐ Chicken
☐ Sulfates	☐ Mercury or Thimerosal	☐ Neomycin, Polymyxin Streptomycin	☐ Other:_____

Medication

Are you taking antibiotics?	____ Yes	____ No
Are you taking heart medications (esp. beta-blockers, quinidine, quinine)?	____ Yes	____ No

OFFICE USE ONLY

Family_____

Single_____

No Charge_____

I certify that the above information is true and accurate to the best of my knowledge.

I authorize my immunization information to be submitted to the Michigan Immunization Registry where I will have access to obtain my immunization status through my medical provider. Upon receipt of a written request from an individual who is 20 years of age or older, the department shall make any immunization information in the registry pertaining to that individual inaccessible.

I understand an HIV (AIDS virus) test or other blood tests may be performed upon me without written consent if a health professional or other health facility employee sustains a skin cut, mucous membrane, or open exposure to my blood or other body fluids during the course of this visit. (Ref: Public Health Code PA368 of 1978, Section 333.5133 as amended 1988)

_____ _____

Signed Date

KALAMAZOO COUNTY GOVERNMENT
In the Pursuit of Extraordinary Governance
Health and Community Services Department

The Health & Community Services programs are open to all without regard to race, color, national origin, sex or disability.

Vaccine Lot Number	Vaccine Lot Number	Vaccine Lot Number
Dtap	HPV9 (Gardasil)	Rota Teq
Dtap IPV	Influenza **Flumist**	Tdap (Boostrix)
Dtap Hep B IPV (Pediarix)	Influenza **p/f 6-35 m**	Tdap (Adacel)
Dtap Hib IPV (Pentacel)	Influenza **p/f 3+**	Typhim (inj)
Hep A Pediatric	Influenza 3y+: IIV3	Typhoid (oral)
Hep A Adult	Influenza 3y+: IIV4	Varicella
Hep A & B (Twinrix)	influenza **High Dose**	Yellow Fever
Hep B Pediatric	IPV	DT
Hep B Adult	Menactra	Menomune
HIB (Pedvax)	MMR	TD-pf
HIB (Acthib)	MMRV	Zoster
	PCV13	
	PPSV23	

REFUSAL TO CONSENT TO VACCINATION

DTaP HIB Hep A Hep B MMR PCV13 IPV RV VAR Flu HPV MCV Tdap/Td YF Typhoid

*I have read the Vaccine Information Sheet(s) explaining the vaccines(s) and disease(s) they prevent. My vaccination provider has explained to me and I understand the following:

*The **purpose** of the recommended vaccination

*The **risks and benefits** of the recommended vaccination

***Possible Consequences** of not allowing my child to receive the recommended vaccination may include contracting the illness the vaccine is intended to prevent and transmitting the disease to others and possible exclusion from school during an outbreak

*KCHCS, the American Academy of Pediatrics, the American Academy of Family Physicians, and the Centers for Disease Control and Prevention (CDC) have all strongly recommended that the vaccines(s) be given.

The vaccination provider has answered all of my questions. I know I can change my mind and accept vaccination for (myself/my child) in the future. I accept sole responsibility for any consequences as a result of (me/my child) not being vaccinated. I acknowledge that I have read this document in its entirety and fully understand it.

Signature_____ Date_____

Nurses Signature_____