**TRAVEL FEE SCHEDULE**

<table>
<thead>
<tr>
<th>NAME</th>
<th>DATE</th>
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*For Internal Use*

- $125  Pre-Travel Consult, per trip
- $35  International Certificate of Vaccination (ICV)
- $35  Phlebotomy (Blood Draw)
- $35  Vaccination administration fee

**PER DOSE PRICE**

- $90  Polio (IPV)
- $85  Tetanus/Diphtheria/Pertussis (Tdap)
- $95  Typhoid: Typhim Vi
- $95  Hepatitis A (series of 2 at $95 each)
- $95  Hepatitis B (series of 3 or 4 at $95 each)
- $155  Hepatitis A&B combination (Twinrix) (series of 3 or 4 at $155 each)
- $195  Yellow Fever
- $165  Meningococcal (Menveo)
- $325  Rabies (pre-exposure series of 3 doses at $325 each; $975 TOTAL)
- $315  Japanese Encephalitis (series of 2 doses at $315 each; $630 TOTAL)
- $185  Pneumococcal: Pneumovax or Prevnar-13
- $65  Influenza, quadrivalent, trivalent or high dose
- $265  Cholera Oral Vaccine

<table>
<thead>
<tr>
<th>Travelers’ Diarrhea</th>
<th>Malaria - Prevention</th>
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<tbody>
<tr>
<td>Azithromycin</td>
<td>Atovaquone/proguanil (Malarone)</td>
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<tr>
<td>Ciprofloxacin</td>
<td>Mefloquine</td>
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<tr>
<td>Rifaximin</td>
<td>Doxycycline</td>
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<tr>
<th>Altitude Illness</th>
<th>Malaria - Self-treatment</th>
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<tbody>
<tr>
<td>Acetazolamide</td>
<td>Atovaquone / Proguanil (Malarone)</td>
</tr>
<tr>
<td>Dexamethasone</td>
<td>Artemether/lumefantrine (Coartem)</td>
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<tr>
<td>Nifedipine</td>
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I ACKNOWLEDGE THAT I HAVE BEEN GIVEN THIS FEE SCHEDULE AND I WILL BE GIVEN THE OPPORTUNITY TO ASK QUESTIONS.

Signature __________________________
Travel Questionnaire

Referred by______________________________________

☐ I am a returning patient

Name____________________________________________

Last   First   Middle Initial

Address_____________________________________________________________________________________

Number, Street   Apt #

________________________ City   ____________________ State   ____________________ Zip Code

Telephone:
Cell_______________________ Home_____________________ Work _________________________

Email Address ____________________________________________________________

☐ Male  ☐ Female   Date of Birth ____________________ Age _____________________________

Pharmacy Information __________________________________________________________

Emergency Contact ___________________________________ Phone # _____________________

* If you want a follow-up letter sent to your primary care physician/referring doctor, complete this section*

☐ I do not wish to have a report sent to my physician OR I do not have a physician

Physician’s Full Name

_____________________________________________________________________________________

First Name   Last Name

Address_____________________________________________________________________________________

Number, Street   Apt/Suite/Floor #

________________________ City   ____________________ State   ____________________ Zip Code
# Health History

## Current Prescriptions, Over-The-Counter Medications and Herbal Supplements

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<thead>
<tr>
<th>Medication</th>
<th>Reason for use / medical condition</th>
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## Pertinent Medical and Surgical History

___________________________________________________________________________________________

## Allergies (check all that apply)

- [ ] Antibiotics (please specify) ____________________________
- [ ] Other medications
- [ ] Eggs
- [ ] Latex
- [ ] Gelatin
- [ ] Yeast
- [ ] Bees / wasps
- [ ] Seasonal
- [ ] Other ____________________________

## Side effects/ reactions from previous medications (name medications):

___________________________________________________________________________________________

## Health History (check all that apply)

- [ ] Steroids by mouth within last 3 months
- [ ] Spleen removed
- [ ] Immune suppressive medications or treatments within past year

- [ ] Thymus disease, thymectomy or Myasthenia Gravis
- [ ] Organ, bone marrow, stem cell transplant
- [ ] HIV/AIDS
- [ ] Other

## Kidney, Neurologic/psychiatric and OG/GYN Conditions (check all that apply)

- [ ] Kidney insufficiency
- [ ] Anxiety / depression
- [ ] Pregnant?
- [ ] Seizures or epilepsy
- [ ] History of Guillain-Barre
- [ ] Planning to become pregnant?

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Please bring all vaccination records to your appointment
Travel Details

☐ I am not traveling

Purpose of Trip (Check all that apply)

☐ Vacation ☐ Education/Research ☐ Visit friends or family ☐ Volunteer/Relief Work

☐ Work (Urban, office-based) ☐ Work (rural, outdoors or in local community) ☐ Relocation

☐ Other: ____________________________________________

Planned Activities: ________________________________________________________________________

Will you be:

- Visiting areas that are:
  ☐ Rural ☐ Urban ☐ Primitive or remote
- Ascending to high altitudes (8,000 ft or higher?) ☐ Yes ☐ No
- Working with potential exposure to bodily fluids (e.g., medical or dental work?) ☐ Yes ☐ No
- Work with exposure to animals? ☐ Yes ☐ No

Accommodations (check all that apply)

☐ Resort / large hotel ☐ Small hotel / guest house ☐ Cruise ship

☐ Private home (with locals) ☐ Private home (with relatives) ☐ Primitive camping

☐ Up-scale camp/lodge ☐ Dormitory/hostel ☐ Other ____________________

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<tr>
<th>Dates</th>
<th>City and Country</th>
<th># Days in each location</th>
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