The student completes this form BEFORE the appointment for a physical examination; then gives it to the clinician.

GSU Clinic
Georgia State University
147 Sparks Hall
33 Gilmer Street, SE
Atlanta, Georgia 30303
Phone: 404-651-2229
Fax: 404-651-4783

# Travel History Form

Name: ______________________________ Student I.D. No.: ______________

Address: ______________________________________________

Today's Date: _____/_____/_____ Date of Birth: _____/_____/_____ ☐ Male ☐ Female

Home Telephone No.: (     ) __________ Cell Phone: (     ) ______________

E-Mail Address: __________ Do you have a current passport or visa? ☐ Yes ☐ No ☐ Don't Know

______________________________________________

## Travel Specifics

Purpose of Trip: ☐ School Related Study/Work What Program? __________________
☐ Pleasure ☐ Business ☐ Other: ______________________________
What will you be doing on this trip:______________________________

______________________________________________

Does your program require the completion of a medical form by a practitioner?…☐ Yes ☐ No
Are you currently enrolled in a health insurance plan that covers you while overseas? … ☐ Yes ☐ No
What insurance coverage do you currently have? ______________________
Departure Date from United States: __________ Return Date to United States __________

| Countries AND cities to be visited in order of visits | Arrival Date | Departure Date |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

A. Have you traveled outside the United States before? ☐ Yes ☐ No
If yes, where and when? ______________________________

B. Will you be:

☐ Yes ☐ No Visiting ONLY urban areas? If no, explain: ______________________
☐Yes ☐ No Staying ONLY in hotels? If no, explain: ______________________
☐ Yes ☐ No Visiting friends and family?
☐ Yes ☐ No Ascending to high altitudes (> 7,000 ft. or 2,300 meters) in the mountains?
☐ Yes ☐ No Working in the medical or dental field with exposure to blood or other body fluids?
☐ Yes ☐ No Working with exposure to animals?
☐ Yes ☐ No Potentially have sexual contact with new partners?

Allergies

1. ☐ No known drug allergies ☐ No known food allergies

Name:________________________________________ Student I.D. No.: _____________________________

2. Have you had any allergic reaction to any of the following? (please check all that apply)

- ☐ Eggs
- ☐ Sulfa Drugs (e.g., Bactrim, Septra, Gantrisin)
- ☐ Antibiotics (e.g., Neomycin, Streptomycin)
- ☐ Thimerosal (preservative in contact lens solution)
- ☐ Chrysanthemums
- ☐ Other: ___________________________________________
- ☐ Quinines (Chloroquine [Aralen], Mefloquine [Lariam] Hydroxycholoroquine [Plaquenil], Primaquine)
- ☐ Pyrimethamine
- ☐ Tetracyclines (Doxycycline, Minocin, Minocyclin, Acromycin, Sumycin)

## Immunizations

1. Were you born in the United States? ☐ yes ☐ no If no, where? ____________________
2. Please submit your immunization records on the form provided as Page 3.

## Medical History

1. Are you using steroids, receiving radiation therapy or other immunosuppressive chemotherapy? ☐ Yes ☐ No
2. List your current prescription medications and medical condition treated: (include birth control pills)

| Current Prescription Medications | Condition or Reason for Use |
|---|---|
| 1. | |
| 2. | |
| 3. | |

3. List regularly used non-prescription medications (over-the-counter, herbal, homeopathic, vitamins, etc.) OR supplements (like those purchased at GNC stores):

| Regularly used Non-Prescription Medications or Supplements | Condition or Reason for Use |
|---|---|
| 1. | |
| 2. | |
| 3. | |

4. Have you been told you have any of the following medical conditions (check all that apply)?

| Yes | No | Family History | | Yes | No | Family History | | Yes | No | Family History | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | Anemia | ☐ | ☐ | ☐ | G6PD Deficiency | ☐ | ☐ | ☐ | Liver Disease/Hepatitis |
| ☐ | ☐ | ☐ | Asthma | ☐ | ☐ | ☐ | Gout | ☐ | ☐ | ☐ | Lung Disease |
| ☐ | ☐ | ☐ | Blood Clotting Problems | ☐ | ☐ | ☐ | Hearing Problem | ☐ | ☐ | ☐ | Prostate Problems |
| ☐ | ☐ | ☐ | Cancer | ☐ | ☐ | ☐ | Heart Disease | ☐ | ☐ | ☐ | Psoriasis/Other Skin Problem |
| ☐ | ☐ | ☐ | Depression | ☐ | ☐ | ☐ | High Blood Pressure | ☐ | ☐ | ☐ | Psychiatric Problems |
| ☐ | ☐ | ☐ | Diabetes | ☐ | ☐ | ☐ | High Cholestero | ☐ | ☐ | ☐ | Sickle Cell Disease |
| ☐ | ☐ | ☐ | Ear Infections Chronic or Frequent | ☐ | ☐ | ☐ | Hormone Problems | ☐ | ☐ | ☐ | Stroke |
| ☐ | ☐ | ☐ | Epilepsy/Seizure Disorder | ☐ | ☐ | ☐ | Immune System Deficiency | ☐ | ☐ | ☐ | Thyroid Problems |
| ☐ | ☐ | ☐ | Eye Problems | ☐ | ☐ | ☐ | Kidney Disease | ☐ | ☐ | ☐ | Other:___________________ |

5. (For Women Only) a. Last normal menstrual period: __________________________________

b. Are you, or could you possibly be pregnant? ☐Yes ☐No; c. Are you breast feeding an infant? ☐ Yes ☐ No

## Questions/Concerns

Please list additional questions or concerns that you might have regarding your travel (i.e., international voltage requirements, currency exchange, dealing with seasickness, etc.)

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Name:____________________________________ Student I.D. No.: ___________________________

# Vaccine Administration Record – Georgia State Study Abroad Program

**Patient Name**: ______________________________________

**Medical Office Stamp**

**(Required):**
**Birth Date:** ______________________________________

**Student Number**:______________________________________

**Instructions:** Before administering any vaccines, give the patient copies of all pertinent Vaccine Information Statements (VISs) and make sure he/she understands the risks and benefits of the vaccine(s). Update the patient's personal record card or provide a new one whenever you administer vaccine.
**Retain copy in medical record, attach a copy to the Physician's Certificate Form; student submits to Study Abroad Program Office.**

| **Vaccine** | | **Type of Vaccine*** (generic abbreviation) | **Date given** (mo/day/yr) | **Route** | **Site given** (RA / LA) | **Vaccine** | | **Vaccine Information Statement** | | **Signature Stamp** |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | Lot # | Mfr. | VIS § Date | Date given § | |
| **Tetanus and Diphtheria** (Td) Must be within the Last 10 years | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| **Hepatitis A†** (HepA, HepA-HepB) | 1 | | | | | | | | | |
| | 2 | | | | | | | | | |
| | 3 | | | | | | | | | |
| **Hepatitis B†** (HepB, HepA-HepB) | 1 | | | | | | | | | |
| | 2 | | | | | | | | | |
| | 3 | | | | | | | | | |
| **Measles, Mumps, Rubella** (MMR) | 1 | | | | | | | | | |
| | 2 | | | | | | | | | |
| **Measles** (if no MMR) | 1 | | | | | | | | | |
| | 2 | | | | | | | | | |
| **Mumps** (if no MMR) | | | | | | | | | | |
| **Rubella** (if no MMR) | | | | | | | | | | |
| **Varicella** (Var) | 1 | | | | | | | | | |
| | 2 | | | | | | | | | |
| **Pneumococcal **** (PPV) | | | | | | | | | | |
| **Influenza** (Flu) If within the last 12 months | | | | | | | | | | |
| **Meningitis** | | | | | | | | | | |
| **OTHER** | | | | | | | | | | |
| **OTHER** | | | | | | | | | | |

*Record the generic abbreviation for the type of vaccine given (e.g., PPV, HepA-HepB), *not* the trade name.

†For combination vaccines, fill in the row for each individual antigen composing the combination.

§Record the publication date of each VIS as well as the date it is given to the patient. According to federal law, VISs must be given to patients before administering each does of Td, MMR, varicella, or hepatitis B vaccine.

**Some high-risk patients need a one-time revaccination with pneumococcal polysaccharide vaccine (PPV).