Student Name: _____ Date of Birth: _____

Shippensburg University – Etter Health Center

Pretravel Health Consult

Today's date _____

Age _____

Sex _____

Cell Number _____

E-mail _____

Address _____

Medical History

Current/Ongoing Medical Conditions

Medical Conditions	Treatment
_____	_____
_____	_____
_____	_____

Current Medications (Prescribed or Over the Counter)

Medication/ Dosage	
_____	_____
_____	_____

Allergies? (Medication or other)

_____

_____

Allergic to:

Eggs Mercury Latex Beestings Gelatin

Do you have any conditions which has or could lower your immune system?

_____

Are you pregnant, could you be pregnant, or are you trying to become pregnant?

_____

Are you breast feeding? _____

Do you have any history of mental health illness? _____

Student Name: _____ Date of Birth: _____

Immunization History (or copy of Immun. Records)

Vaccine	**Date of Vaccine (s) or Disease**
MMR_____	
Chicken Pox _____	
Hep A_____	
Hep B _____	
Td/Tdap _____	
Polio _____	
Meningitis _____	
Other vaccines _____	

Travel

US Departure Date _____ US Return Date _____

Travel Location - Arrive/ Depart

_____ _____

_____ _____

Recommendations

Immunizations	Prescription Medicines
_____	_____
_____	_____
_____	_____

Other Recommendations:

_____

_____

These recommendations are being made based on the review of your medical history and travel plans. It is the sole responsibility of the student to obtain and pay for the recommended treatments/medications.

Student Signature _____

Dr. / Nurse Signature_____