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Pre-Travel Worksheet

INSTRUCTIONS:

Please fill in the entire front page of the pre-travel worksheet. Your consultation will be specifically tailored to your itinerary. The more details you can provide regarding your itinerary, the better we can prepare you for a safe and healthy travel experience. Please bring with you, or verify, that we have a copy of your immunization records.

Name: _____	DOB: _____	Preferred Pronoun: _____
UO Student ID#: _____	Phone#: _____	Country of Birth: _____
Email Address: _____	@uoregon.edu	Departure Date: _____
Main Country of Stay: _____		Return Date: _____
Program Start & End Dates: _____		

1. What is the purpose of your travel? (Study abroad, vacation, volunteer, internship, medical mission, etc.)
2. What is the name of your program?
3. Do you plan on any travel outside of your program’s excursions? YES NO Where?
4. Please list all the countries, in the order of travel, that you will be visiting, or consider visiting:

1. Country _____	Region/Cities _____	Travel Date/Duration _____
2. Country _____	Region/Cities _____	Travel Date/Duration _____
3. Country _____	Region/Cities _____	Travel Date/Duration _____
4. Country _____	Region/Cities _____	Travel Date/Duration _____
5. Country _____	Region/Cities _____	Travel Date/Duration _____
6. Country _____	Region/Cities _____	Travel Date/Duration _____
7. Country _____	Region/Cities _____	Travel Date/Duration _____

***For travels to multiple destinations, attach a separate sheet of paper. If you have a specific itinerary with travel dates, please bring it to your appointment.**

5. What is your living situation going to be? (home stay, dorm, hostel/hotel, camping, etc.)
 - a) During program stay:
 - b) During other travel:
6. Please list all planned and possible activities (backpacking, hiking, high altitudes, scuba diving, etc.)
7. Do you have any health concerns regarding your travel?
8. Have you had a major medical condition that was diagnosed or treated?
9. Have you been evaluated or treated for depression, anxiety, eating disorder or other mental health condition?
10. Is there any chance you could be pregnant? YES NO
11. Do you have any allergies to medications, food, etc.?
12. What prescription medications are you taking including any Birth Control you are using (Nexplanon, IUD, Depo)?
13. List any previous travel experience you have outside of the United States in the past 3 years?
14. Physical appointment scheduled with _____ on: _____
15. Do you need any documents associated with this travel notarized? YES NO

PLEASE BRING YOUR IMMUNIZATION RECORDS TO YOUR TRAVEL APPOINTMENT

PLEASE DO NOT WRITE ON THE BACK OF THIS PAGE, IF NECESSARY ATTACH A SEPARATE SHEET OF PAPER

Appointment Date:

Time:

FOR HEALTH CENTER STAFF ONLY

Immunization History

Hepatitis A #1 _____ #2 _____

Hepatitis B #1 _____ #2 _____ #3 _____ #4 _____

Twinrix #1 _____ #2 _____ #3 _____ #4 _____

HPV #1 _____ #2 _____ #3 _____

Influenza _____

Japanese Encephalitis #1 _____ #2 _____

MMR #1 _____ #2 _____

Meningococcal _____

Meningococcal B _____

Pneumococcal _____

Polio _____

PPD (Placed) _____ (Read) _____

Rabies #1 _____ #2 _____ #3 _____

Tdap/TD _____

Typhoid (Oral) _____ (Injectable) _____

Varicella #1 _____ #2 _____

Yellow Fever _____ Other _____

RX AND OTHER

Malaria Prophylaxis #1 _____ #2 _____

Malaria Treatment (Sub-Sahara) _____

Diarrhea #1 _____ #2 _____

Syringe Pack Given YES _____ NO _____

NURSING NOTES