

Date of visit _____

Boston University Student Health Services
TRAVEL IMMUNIZATIONS AND ADVICE

Name _____

Time _____

UID _____

PLEASE COMPLETE THIS FORM PRIOR TO COMING TO YOUR TRAVEL RELATED VISIT. TRAVEL PLANS SHOULD BE MADE 4-6 WEEKS IN ADVANCE OF YOUR TRAVEL. VISIT WWW.CDC.GOV/TRAVEL/ AND PRINT INFORMATION ABOUT YOUR TRAVEL DESTINATIONS BEFORE YOUR VISIT.

Home phone		Work	Cell
Countries (not continents) in chronological order of visit	Urban or Rural or Resort only	Date or arrival to country	Date of departure from country
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Will you be exposed to any animals? Y N

Is there any chance you could be pregnant? Y N Last menstrual period _____

Do you live with anyone who is immunocompromised? Y N

Are you currently being treated for a mental health problem? Y N
Please describe:

Current Medications:

Active medical problems: (status of disease)

- Epilepsy
- Depression
- Immunocompromise
- G6PD deficiency

Allergies to medications:

Prov init