

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. TRAVELS PLANS SHOULD BE MADE 4-6 WEEKS IN ADVANCE OF YOUR TRAVEL. VISIT [WWW.CDC.GOV/TRAVEL/](http://www.cdc.gov/travel/) AND PRINT INFORMATION ABOUT YOUR TRAVEL DESTINATIONS BEFORE YOUR VISIT.

Home ph		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

Current Medications:

Active medical problems: (status of disease)

Seizures/epilepsy _____

Depression _____

Allergies to medications:

Immunocompromise or on steroids _____

G6PD deficiency _____

Prov init