University Health Center
Student Affairs
UNIVERSITY OF GEORGIA

Name:_____
UGA ID:_____
Date of Birth:_____
Phone:_____

UNIVERSITY HEALTH CENTER – TRAVEL CLINIC

Please fill out this form and email allergytravel@uhs.uga.edu or fax (706) 583-8255. Once we receive your completed paperwork we will contact you to schedule an appointment

**Before sending any forms via email, please be aware of the possible risks of using unencrypted email. These forms contain protected health information and are confidential. The use of unencrypted email and any attachment could result in an unintentional disclosure of your protected health information. If you use email, you have decided that the risks with email communications are acceptable to you and you hereby release the University of Georgia for any such disclosure unless caused by the negligence of UGA. If not, you may fax the forms to us.*

Have you been seen as a patient at the University Health Center (UHC)? ☐ YES ☐ NO

Charges: office visit fee $80 (complex, e.g. 3 or more countries $110) + vaccines, prescriptions, and/or lab charges

Insurance: You will need to verify your insurance coverage for travel services and immunizations. Please see Good Faith Estimate and Fees online where you found this document

**Initial visits are approximately 30-40 minutes

**$30 no show fee for all patients that do not provide 24-hour notice to cancel appointment

I. COMPLETE ITINERARY: List ALL planned countries in chronological order.

_____

_____

_____

DEPARTURE Date: _____ **RETURN Date**: _____

Do you have a "Yellow Card"? ☐ Y ☐ N

Are you traveling with a US Passport? ☐ Y ☐ N or other Country _____

UGA Program? ☐ Y ☐ N && Name of UGA Program: _____

Personal Trip? ☐ Y ☐ N

What type of living arrangements? (eg. camping, hotel, hostel, etc.) _____

_____

What activities are you doing? (eg. caving, hiking, water sports, research, attending a conference, etc.)

_____

_____

Effective Date: 7/2021 Reviewed:
Revised: 7/2022, 4/2023,7/2023

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II. IMMUNIZATION RECORDS: Please bring immunization records including Yellow Card and out of state records to your appointment. We have access to the Georgia State Registry "GRITS".

III. MEDICAL HISTORY:

a. ALLERGIES: _____ **□ No Drug Allergies**

_____

Neomycin	☐ Y ☐ N	Penicillin	☐ Y ☐ N	Streptomycin	☐ Y ☐ N
Eggs	☐ Y ☐ N	Sulfa	☐ Y ☐ N	Insect Bites/Stings	☐ Y ☐ N

b. MEDICATIONS: **Please list prescription and over the counter medications that you take

_____

_____

c. MEDICAL HISTORY (Check **all** that apply) **□ No Medical Problems**

□ Asthma □ Autoimmune Disorder □ Depression □ Diabetes □ Anxiety □ Heart Problem

□ Immune Suppression □ Kidney Problem □ Liver Problem □ Psychological Problem □ Thymus Problem

□ Other/Comments: _____

□ Past Surgeries: _____

Do you smoke? ☐ Y ☐ N
Are you currently pregnant or trying to become pregnant? ☐ Y ☐ N
Are you currently breastfeeding? ☐ Y ☐ N

By signing below, I acknowledge that I am responsible for all fees incurred by scheduling a Travel Appointment

Signature: Date: _____

If unable to use the signature function: My typed name below is my conformed signature.

/s/ _____ Date: _____