ASPETUCK HEALTH DISTRICT
180 Bayberry Lane, Westport, CT 06880
Tel: (203) 227 9571 | Fax: (203) 221 7199 | https://aspetuckhd.org

Travel Clinic Form

Hello,

Thank you for your interest in scheduling a travel visit. Your visit will be with Vanessa Hurta, APRN. Please complete the attached forms and fax them to 203.221.7199 or mail them back to us at 180 Bayberry Lane, Westport, CT 06880. Once we have received these, we will call you to schedule your appointment. If you email it, it will not be HIPAA-secure.

You will find the office visit and vaccine prices in the fee schedule on our website. If you schedule a group visit, please note that your medical history will be reviewed in a group setting. Your insurance may cover some vaccinations, such as polio, meningitis, and hepatitis, but many travel vaccines will not and will be charged to you at the time of your visit. Ask us for details when scheduling an appointment. Please bring a copy of your identification and insurance card to your visit. We carry the standard travel vaccinations, but note that cholera, tick-borne encephalitis, and chikungunya may need to be specially ordered, so let us know ahead of time if you think you are a candidate for these vaccines.

If you do not have your records, it is essential to ask your health care providers for a list of travel and routine vaccines you have received in the past. Bring these records to your appointment or submit them ahead of time. Otherwise, we may recommend vaccines that are not necessary and costly.

We look forward to our visit and hearing about your trip!

Sincerely,

Aspetuck Health District Community Health
communityhealth@aspetuckhd.org
203-227-6611

ASPETUCK HEALTH DISTRICT
180 Bayberry Lane, Westport, CT 06880
Tel: (203) 227 9571 | Fax: (203) 221 7199 | https://aspetuckhd.org

Travel Clinic Form

1. I have made or will make every attempt to gather my vaccination history before my appointment and bring it to the appointment. Family members, medical providers, and CT Wiz have or will be utilized. CT Wiz is the state's vaccine registry and can be accessed here https://ctwizpublicportal.dph.ct.gov/
2. I have read the Aspetuck Health District's HIPAA Privacy Policy posted on the website, including information disclosures and how to obtain access to information.
3. I acknowledge that my insurance provider may not cover vaccines and that payment for my office visit and vaccines must be made at the time of the visit. If I have any questions, I will contact my insurance provider.
4. Prior to receiving my vaccines, I will read all the given information about immunizations, potential side effects, risks, and ask any questions. If I am pregnant, breastfeeding, or considering pregnancy or breastfeeding, I must make the provider aware of my health history on the form. If I am pregnant or breastfeeding, or considering pregnancy or breastfeeding, I may not receive some vaccines. I understand that I should not become pregnant three months after receiving the oral typhoid, MMR, Yellow Fever, or chickenpox vaccine. I understand that live vaccines produce a mild infection that provides immunity. I am aware of the potential risks of receiving vaccines.
5. A parent or legal guardian must be present when a person under 18 is receiving travel-related services. A child must weigh over 33 lbs to be vaccinated here.
6. I understand that if I email personal health information, it may not be HIPAA-secure.

Please fax forms to our HIPAA secure fax at 203-221-7199

I acknowledge that I have read the above information.

Name: _____

Signature _____ Date: _____

Parent/Guardian Name if patient under 18: _____

Signature: _____ Date: _____

ASPETUCK HEALTH DISTRICT TRAVELER HISTORY FORM.

Name: _____ Age: _____DOB: _____

Gender: _____ Phone #1: _____ Phone #2: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Email: _____

May we email you a "traveler report" based on your itinerary? ___

Primary care physician: _____ Pharmacy and street/city/state: _____

Do you have medical evacuation insurance? _____ If using a tour group or agency, please list: _____

CT Wiz is CT's Immunization Registry that stores your vaccine history. If you do not want your vaccines submitted to CT Wiz, you must send a signed written request to the CT Dept of Health. CT Wiz also collects:

Race: _____Preferred language: _____Ethnicity: ☐ Hispanic ☐ non-Hispanic

TRAVEL PLANS (list additional information on back of form if needed):

Purpose of trip and planned activities: _____

_____

Will you be:

Visiting areas that are:

- Rural ☐Yes ☐No ☐Not sure
- Urban ☐Yes ☐No ☐Not sure
- Primitive or remote ☐Yes ☐No ☐Not sure

Ascending to high altitudes (8,000 ft or higher)? ☐Yes ☐No ☐Not sure

Working with potential exposure to body fluids (e.g., medical or dentalwork)? ☐Yes ☐No ☐Not Sure

Working with exposure to animals? ☐Yes ☐No ☐Not sure

Potentially having new sexual partners?☐Yes ☐No ☐Not sure

Accommodations (check all that apply):

☐ Resort/large hotel ☐Small hotel/guest house/B&B ☐Cruise ship ☐Private home ☐Primitive camping ☐Up-scale camp/lodge ☐Dormitory/ hostel ☐Other _____

CITY/TOWNS AND COUNTRIES in order of visit	Arrival Date	Departure Date

Name	DOB	Date

HEALTH HISTORY (Check all that apply)

Allergies
- ☐ Antibiotics (e.g., penicillin, sulfa) _____
- ☐ Other medications _____
- ☐ Egg
- ☐ Latex
- ☐ Gelatin
- ☐ Yeast
- ☐ Bees/wasps
- ☐ Seasonal
- ☐ Other _____
- ☐ Side effects/reactions from previous medications (e.g., nausea, dizziness, stomach upset): _____

Cancers/blood disorder
- ☐ Coagulation disorder
- ☐ History of cancer or blood disorder
- ☐ Other _____

Cardiovascular
- ☐ Arrhythmia (rhythm disturbance considered significantly abnormal including atrial fibrillation, heart block)
- ☐ Implanted pacemaker or automatic defibrillator
- ☐ Heart attack
- ☐ High cholesterol
- ☐ High blood pressure
- ☐ Stroke
- ☐ Other _____

Endocrine
- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Other _____

GI
- ☐ Crohn's disease or ulcerative colitis
- ☐ IBS
- ☐ GERD
- ☐ Chronic hepatitis
- ☐ Cirrhosis or liver failure
- ☐ Other _____

Immune system
- ☐ Steroids by mouth within last 3 months
- ☐ Immune suppressive medications or treatments within last 3 months (e.g., radiation, cancer chemotherapy drugs, methotrexate, azathioprine, adalimumab, anakinra, etanercept, infliximab, leflunomide, rituximab)
- ☐ Spleen removed
- ☐ Thymus disease or thymectomy
- ☐ HIV/AIDS
  - Most recent CD4: _____
  - Most recent viral load: _____
- ☐ Organ, bone marrow, stem cell transplant _____
- ☐ Other _____

Kidneys
- ☐ Dialysis
- ☐ Kidney insufficiency
- ☐ Other _____

Lungs
- ☐ Asthma
- ☐ Emphysema/COPD
- ☐ Other _____

Musculoskeletal
- ☐ RA
- ☐ Psoriatic arthritis
- ☐ Other _____

Neurologic/psychiatric
- ☐ Seizures or epilepsy
- ☐ Anxiety /depression
- ☐ History of Guillain-Barré
- ☐ Other _____

Skin
- ☐ Psoriasis
- ☐ Other _____

OB/GYN
- ☐ Pregnant: _____weeks/trimester
- ☐ Breastfeeding
- ☐ Possible pregnancy in next 3 months
- ☐ Other _____

VACCINATION HISTORY
(Please bring all vaccination records to your appointment.)

Have you received the following immunizations?

Hepatitis A	☐ Yes When? _____	☐ No	☐ Not sure
Hepatitis B	☐ Yes When? _____	☐ No	☐ Not sure
Meningococcal	☐ Yes When? _____	☐ No	☐ Not sure
Measles/Mumps/Rubella	☐ Yes When? _____	☐ No	☐ Not sure
Polio	☐ Yes When? _____	☐ No	☐ Not sure
Tetanus	☐ Yes When? _____	☐ No	☐ Not sure
Typhoid	☐ Yes When? _____	☐ No	☐ Not sure
Yellow Fever	☐ Yes When? _____	☐ No	☐ Not sure
Japanese Encephalitis	☐ Yes When? _____	☐ No	☐ Not sure
Influenza	☐ Yes When? _____	☐ No	☐ Not sure

Other _____

Have you ever had an adverse reaction to an immunization? ☐ No ☐ Yes Explain: _____

_____

Name	DOB	Date

CURRENT MEDICATIONS

Prescription medications: List all current prescription medications

Medication	Reason for use/medical condition

Non-prescription products: List current over the counter, herbal, homeopathic products, vitamins, supplements, etc.

Product	**Reason for use/medical condition**

QUESTIONS/CONCERNS

Additional questions or concerns about your travel: