REQUEST FOR INTERNATIONAL TRAVEL HEALTH NEEDS

TODAY'S DATE: _____

Patient Name: _____ Parent or Contact Name: _____

Patient DOB: _____ Contact Relationship to Patient: _____

Phone Number of Contact: _____ Provider:_____

List of Countries in Order including Connecting Flights/Layovers and # Days in Each Country:

_____

_____

_____

List of Regions/Cities/Countryside/Towns Visiting (Include itinerary if you have one)

_____

_____

Purpose of Travel: (e.g. Habitat for Humanity, Missionary Work, Leisure, etc.)

_____

Departure Date: _____ Duration of Stay: _____

Current Medications: Allergies:

10807 FALLS ROAD, SUITE 200, LUTHERVILLE, MD 21093 PHONE: (410) 321-9393 FAX: (410) 825-4945

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Patient Name: _____ Patient DOB: _____

FOR OFFICE USE ONLY

Vaccines:

Available Here:

All routine
Hepatitis A
Oral Typhoid: #4 one Q.O.D.
Others at Travel Clinic

Medications:

Malaria: Malarone _____

Chloroquine _____

Antibiotic: _____

Chronic Medications Needed: _____

Appointment Date and Time: _____

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