DeKalb PUBLIC HEALTH

LABEL

Patient Travel Consultation

Departure date from U.S. _____

Patient Home Phone: _____

Patient Work Phone: _____

TRAVEL ITINERARY

Destination(s) (Separate urban or rural areas and regions of the country.)	**Date of Arrival at destination**	**Departure date from destination**	**Length of Stay at each destination**

MEDICAL HISTORY

Childhood Immunizations Up To Date ☐**Yes** ☐**No** ☐**Unknown**

Medical Conditions:

- ☐Hypertension
- ☐Cardiovascular Disease
- ☐Diabetes
- ☐Epilepsy
- ☐Other: _____

Current Medications or Treatments:

Allergies to Medication or Food:

Vaccinations or Medications for this Trip from Other Providers: