



Florida Department of Health in Highlands County

Travel Vaccine Questionnaire

7205 S. George Blvd
Sebring, FL 33875
(863) 386-6040

All travel vaccine visits require an appointment. Please completely fill out this form and fax to the travel clinic of your choice listed above. Also, please bring the completed form with you to your appointment.

IMPORTANT NOTICE

- Please bring all previous immunization records (or legible copies) with you to your initial visit.
- Travel vaccines are a very important tool in the prevention diseases, specifically those associated with travel outside of the United States.
- The FDOH in Highlands County travel clinics use the latest recommendations from the CDC in regard to providing you with information about vaccines and other forms of prevention. **CDC's [Travelers' Health](http://www.cdc.gov/travel) website : www.cdc.gov/travel

Today's Date: _____ Full Name: (as it appears on passport or state issued ID) _____ Date of Birth _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Primary Care Provider: _____ Pharmacy of Choice: _____

TRAVEL ITINERARY INFORMATION

Many vaccinations and prophylactic treatments are dependent upon the actual regions and cities that you may be visiting. In order to help you best prepare for your travels as well as spare you any unnecessary costs, please give as much detail as you are able regarding your plans.

| Date of Initial Departure: | | Date of Return: |
|----------------------------|--------------------------|-----------------|
| Destination | Method of Transportation | Length of Stay |
| | | |
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Please bring a copy of your flight itinerary if possible.

Organization or Group Associated with Travel: _____

What will be the primary purpose of this trip: _____

Please describe in detail all that is known about your lodging and dining arrangements for this trip: _____

Please list any **current** medical conditions: _____

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| | |

Please list any **current** medications: _____

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| | |

Please Circle your answer for the below questions:

Are there any medications to which you have had an allergic reaction? Yes No

| If yes, Please list medications: | If yes, Please list type of reaction: |
|----------------------------------|---------------------------------------|
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