



Instructions:

Please **provide as much information as possible** so we can best serve you, and be sure to **submit your form promptly** so you can schedule your appointment.

Use free Adobe Reader to complete this form so you can type, save and print your form. Apple product users, **do NOT use Preview** because it causes problems e.g. blank forms.

To deliver your form:

- Email to UHS-forms@med.umich.edu (“med” is required in this email address; email is not secure, may not be read every day, and should not be used for urgent or sensitive issues) OR
- Deliver printed forms Mon-Fri to Appointment Scheduling, 2nd floor UHS

About you:

Your name – Last: _____ First: _____ Date of Birth: _____

Are you traveling with a U-M group? _____ If yes, which one? _____

Best phone number: _____

Itinerary: List your primary destination(s), plus any travel before and after that location.

Destination -- country & location:	Arrival date:	Departure date:	Accommodations e.g. hotel, camp	Overnight in rural area?
USA, Ann Arbor				
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Health information:

Current medications and supplements: _____

Allergies, medical and other: _____

Chronic medical conditions: _____



Your name – Last: _____ First: _____ Date of Birth: _____

This information will be used to determine which immunizations and medications you need and will receive at your clinic visit. If your program does not pay, you would be responsible for payment at time of service.

Your immunization history is (check all that apply):

- Marked below -- Who completed this information?
 - Student Other (specify): _____
- Attached -- be sure to include patient's name and date of birth on any attachments
- Previously submitted to UHS -- note: UHS does not have access to immunizations records that you may have given to another U-M unit
- Other (specify): _____

Diphtheria-Tetanus- Pertussis (DTaP):

Primary series Dose 1: month____ day____ year____
 Dose 2: month____ day____ year____
 Dose 3: month____ day____ year____
 Dose 4: month____ day____ year____
 Dose 5: month____ day____ year____
 Booster: Td Tdap
 month____ day____ year____

Hepatitis A: Dose 1: month____ day____ year____
 Dose 2: month____ day____ year____

Hepatitis A+B Combination (TWINRIX):
 Dose 1: month____ day____ year____
 Dose 2: month____ day____ year____
 Dose 3: month____ day____ year____

Hepatitis B: Dose 1: month____ day____ year____
 Dose 2: month____ day____ year____
 Dose 3: month____ day____ year____

Influenza: month____ day____ year____

Japanese Encephalitis:
 Dose 1: month____ day____ year____
 Dose 2: month____ day____ year____

Meningitis (Meningococcal):
 Initial: month____ day____ year____
 Booster: month____ day____ year____

Measles, Mumps, Rubella (MMR):

Dose 1: month____ day____ year____
 Dose 2: month____ day____ year____

Polio:

Primary series Dose 1: month____ day____ year____
 Dose 2: month____ day____ year____
 Dose 3: month____ day____ year____
 Dose 4: month____ day____ year____
 Adult booster: month____ day____ year____

Rabies Pre-Exposure:

Dose 1: month____ day____ year____
 Dose 2: month____ day____ year____
 Dose 3: month____ day____ year____

Typhoid: Oral Intramuscular (shot)
 month____ day____ year____

Varicella: Had disease: month____ day____ year____
 Dose 1: month____ day____ year____
 Dose 2: month____ day____ year____

Yellow Fever: month____ day____ year____

Tuberculosis Test:

Result: _____ month____ day____ year____

Other including positive titers (test for immunity):
 _____ month____ day____ year____
 _____ month____ day____ year____