

Important Facts About Your Travel Appointment



Please read, acknowledge by checking the boxes, and sign this document. Once we receive the completed paperwork, we will contact you to schedule an appointment.

- Please arrive to your primary care appointment at least 15 minutes before your scheduled appointment time. *You must see the physician first before you can go to your appointment in the Travel, Immunization & Allergy Injection Department.*
- Please check in at the self-check-in kiosk in the front lobby when you arrive and proceed to the designated care team.
- You are responsible for all charges incurred. Please review the attached price lists. If you are unsure of your insurance coverage, please call and verify before your scheduled appointment. *SHS accepts **ONLY** the Student Health Insurance Plan.* We do not accept any of the insurance plans offered to faculty and staff at Georgia Tech.
- If you arrive late to an appointment and you do not cancel your appointment within 24 hours of your scheduled appointment; you will be charged a no show fee of \$25.00 for each appointment missed.**
- If you have a yellow card, please bring it with you to your appointment
- PLEASE MAKE SURE YOU EAT BEFORE YOUR APPOINTMENT.**

If you have additional questions, please call our office at (404) 385-4995

I have read and understand the above information.

Print Name

Signature

Date

GT ID Number

For Staff Use Only

Your 1st Appointment

Date:

Time:

Location:

Your 2nd Appointment

Date:

Time:

Location: Travel, Immunization & Allergy
Injection Department

**GEORGIA INSTITUTE OF TECHNOLOGY
Travel Visit Request Form**



Complete and *email or fax with copy of buzz card to travel@health.gatech.edu or (404) 894-6254.

**Before sending any forms via email, please be aware of the possible risks of using unencrypted e-mail. These forms contain protected health information and are confidential. The use of unencrypted e-mail and any attachment could result in an unintentional disclosure of your protected health information. If you use email, you have decided that the risks with e-mail communications are acceptable to you and you hereby release the Georgia Institute of Technology ("GIT") for any such disclosure unless caused by the negligence of GIT. If not, you may fax the forms to us.*

Appointment Request Form

Please read and complete the following form.
Illegible handwriting or failure to complete form properly will result in delayed appointment scheduling.

Name: _____ DOB: _____

GTID #: _____ Student Faculty/Staff

Email: _____

Phone #: _____ Today's Date: _____

Do you have the GT BlueCross/BlueShield student insurance plan?
(Circle One) Y N **(Students Only)**

I. COMPLETE ITINERARY- List in chronological order **ALL STOPS** your mode of transportation will make, whether you disembark or not. This does affect vaccine requirements. This list includes layovers and destinations by country, as well as return itinerary. **If you are being seen for several upcoming trips, list itineraries separately (attach extra sheet if necessary).**

TRAVEL STOP #1		Arrival Date:	Duration:	Departure Date:
TRAVEL STOP #2		Arrival Date:	Duration:	Departure Date:
TRAVEL STOP #3		Arrival Date:	Duration:	Departure Date:
TRAVEL STOP #4		Arrival Date:	Duration:	Departure Date:

Total Trip Duration: _____

Do you have a "yellow card"? Yes No

Personal Trip? Yes No / GT Sponsored? Yes No (if yes, name of the program) _____

What type of living arrangements? (camping, hotel, hostel, etc.) _____

What activities are you doing? Caving Hiking Water Sports Research Attending a conference
 Farms/Rural Area Working with animals Study Abroad

Other: (please specify) _____

II. IMMUNIZATION RECORDS:

Students: Did you submit all required immunization forms upon admission to Georgia Tech? Y N
Please fax or email documentation of any additional immunizations you have with this form.

Faculty/Staff: In order for the provider to recommend the most accurate preventative care, *please fax or email documentation of any immunizations you have.* If no immunization records are available, the provider will recommend all vaccines needed—including routine adult vaccines.

III. MEDICAL HISTORY

a. ALLERGIES (check "None" or complete the table below) None

Neomycin	Y N	Penicillin	Y N	Streptomycin	Y N
Eggs	Y N	Sulfa	Y N	Insect Bites/Stings	Y N

Other Drug Allergies: _____

b. MEDICATIONS (Includes over-the-counter medications, vitamins, birth control)

Please list all medications that you take daily or as needed.

c. MEDICAL HISTORY (Check all that apply.)

- Asthma Autoimmune Disorder Depression Diabetes Generalized Anxiety
 Heart Problem Kidney Problem Liver Problem Psychosis Schizophrenia Seizures
 Thymus Dysfunction Other: _____ None
 Past Surgeries: _____

Do you smoke? Y N

Are you currently pregnant or attempting to become pregnant? Y N

Are you currently breastfeeding? Y N

Are you requesting a Statement of Wellness or a physical exam in addition to your travel consultation? Y N
If yes, have you submitted the physical exam form? Y N

***By signing below, I acknowledge that I am responsible for all fees incurred by scheduling a Travel Appointment.**

Signature _____ Date _____

FOR OFFICE USE ONLY

Appointment Type: Travel Only Travel & Physical Appointment

Application Received: _____ Date patient was contacted: _____

Please note, there is a \$25.00-\$50.00 missed appointment fee