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

<table>
<thead>
<tr>
<th>Your 1st Appointment</th>
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<tbody>
<tr>
<td>Date:</td>
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<tr>
<td>Time:</td>
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<tr>
<td>Location:</td>
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<tr>
<th>Your 2nd Appointment</th>
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<tbody>
<tr>
<td>Date:</td>
</tr>
<tr>
<td>Time:</td>
</tr>
<tr>
<td>Location: Travel, Immunization &amp; Allergy Injection Department</td>
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</tbody>
</table>
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.

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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)

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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).

<table>
<thead>
<tr>
<th>TRAVEL STOP #1</th>
<th>Arrival Date:</th>
<th>Duration:</th>
<th>Departure Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>TRAVEL STOP #2</td>
<td>Arrival Date:</td>
<td>Duration:</td>
<td>Departure Date:</td>
</tr>
<tr>
<td>TRAVEL STOP #3</td>
<td>Arrival Date:</td>
<td>Duration:</td>
<td>Departure Date:</td>
</tr>
<tr>
<td>TRAVEL STOP #4</td>
<td>Arrival Date:</td>
<td>Duration:</td>
<td>Departure Date:</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Drug</th>
<th>Y</th>
<th>N</th>
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</thead>
<tbody>
<tr>
<td>Neomycin</td>
<td></td>
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<tr>
<td>Penicillin</td>
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<tr>
<td>Streptomycin</td>
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<tr>
<td>Eggs</td>
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<tr>
<td>Sulfas</td>
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<tr>
<td>Insect Bites/Stings</td>
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</tbody>
</table>

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