UNC ENVIRONMENT, HEALTH & SAFETY

University Employee Occupational Health Clinic – UEOHC

Request for Travel Immunizations for University Business

Complete all information in the forms and fax to UEOHC at 919-966-6337. UEOHC will contact you shortly. This form constitutes authorization for vaccination(s) or other services required for job duties.

EMPLOYEE INFORMATION

Name: PID:

Job Title:

Department: CB#:

Authorized Department Representative:

CHARTFIELD STRING

Note: Cannot use Grants/OSR funding.

Unit: Fund: Source: Account: Dept:

THE FOLLOWING MUST BE COMPLETED BY AUTHORIZED DEPARTMENT REPRESENTATIVE

_____ I verify that the above individual is an employee of the University of North Carolina – Chapel Hill.
Initials

_____ I grant authorization for the above employee to have the requested services and understand that the department will be billed for these services.
Initials

_____ _____
Department Representative Title

_____ _____
Signature Date

Revised: September 2014

UNC ENVIRONMENT, HEALTH & SAFETY

Pre-Travel Health Consultation and History Form

Date:

PERSONAL INFORMATION

Traveler's Name: PID:

Medical Record Number:

Department Name: CB#:

Work Telephone Number: Fax:

Email Address:

TRIP INFORMATION

Have you traveled internationally in the past? ☐Yes ☐No

Do you have documentation of previous immunizations? ☐Yes ☐No

If yes, please bring the documentation to your appointment.

Itinerary: Please give ALL countries to be visited, including stopovers, in order with departure and return dates for each.

1.
2.
3.
4.
5.

Destination: ☐Urban ☐Rural ☐Remote ☐At High Altitude ☐Beach

Purpose of business trip (check all that apply):

☐Medical Care ☐Business ☐Education ☐Research

☐Other:

HEALTH HISTORY

Do you have any chronic health problems for which you take medication on a regular basis to see a health care provider? ☐Yes ☐No

If yes, please explain:

Are you currently being treated for any health problem? ☐Yes ☐No

If yes, please explain:

ALLERGIES

Medication(s)	☐Yes	☐No	If yes, list:
Reaction to vaccine	☐Yes	☐No	If yes, list:
Egg or other food	☐Yes	☐No	If yes, list:
Bee Stings	☐Yes	☐No	If yes, list:
Animals	☐Yes	☐No	If yes, list:
Environmental	☐Yes	☐No	If yes, list:

(pollens, dust, hay fever, etc.)

Have you ever experienced anaphylaxis (severe allergic reaction)? ☐Yes ☐No

MEDICATIONS

Please list all prescribed and over-the-counter medications and supplements you use:

Medication or supplement:	Reason for use:
1.	
2.	
3.	
4.	
5.	

FEMALES

Are you currently or are you trying to become pregnant? ☐Yes ☐No

_____ _____

Traveler's Signature Date

_____ ☐RN ☐PA ☐MD

UEOHC Medical Provider's Signature