MISSISSIPPI STATE UNIVERSITY™

LONGEST STUDENT HEALTH CENTER
P.O. Box 6338
Mississippi State, MS 39762
P. 662.325.2431
F. 662.325.8888
E. health@msstate.edu
healthcenter.msstate.edu

TRAVEL IMMUNIZATION PACKET

Immunization records must be attached prior to scheduling an appointment. Please call (662) 325-2431, option 1 if you have any questions.

This form must be filled out completely and submitted six to eight weeks prior to departure. Any child under 18 years of age must be accompanied by a parent/guardian.

NAME: ____

DATE OF BIRTH:_____/_____/_________**PHONE NUMBER:** (______)_____- ______

DEPARTURE/RETURN DATES:_____/_____/_________to_____/_____/ _________

COUNTRY	DURATION (WEEKS)	URBAN / RURAL
___________________________	______	______ ______
___________________________	______	______ ______
___________________________	______	______ ______
___________________________	______	______ ______
___________________________	______	______ ______

HIGH ALTITUDES: YES NO **PREGNANT:** YES NO

MEDICAL PROBLEMS:

____

CURRENT MEDICATIONS: ____

ALLERGIES: ____

REASON FOR TRAVEL: ____

IMMUNIZATION HISTORY:

*****************Please provide a copy of your immunization record(s). ************************

We need your immunization history in order to prescribe the recommended/required vaccinations.

IMMUNIZATION RECORD MUST BE ATTACHED PRIOR TO SCHEDULING AN APPOINTMENT.

Responsibilities of the Traveler

Seeking and Following Pre-Travel Health Advice

Obtaining pre-travel health care and advice from a clinician familiar with travel is an important step in preparing to travel internationally. Ideally, this visit should take place 4-6 weeks before travel but even getting a consultation the week before travel can be of value. The pre-travel visit includes a discussion of immunizations, prophylactic medications (such as anti-malaria drugs), and specific health advice for preventing and treating traveler's diarrhea and other illnesses the traveler may encounter.

Please have only one clinician perform your entire travel clinic visit, as certain immunizations require a waiting period before you can receive other injections.

Submit a list of current immunizations when requesting an appointment.

Financial Agreement

There is a $75 charge for the Travel Clinic consultation (office visit). This fee is an out-of-pocket charge. Employees and Students in good standing have the option of paying this fee prior to seeing the provider or allowing the LSHC to apply this charge directly to their Banner accounts. All other patients are required to pay this fee prior to receiving services. Please confirm with the front desk that you are able to transfer to Banner. This fee is not filed with insurance.

Other charges such as immunizations, medications, vaccine administration, lab tests, and x-rays will be submitted to the insurance on file for the patient; however, we cannot guarantee these services will be covered. Most insurance companies DO NOT pay for services related to Travel Clinics. Yellow Fever and Typhoid immunizations are not covered, and *insurance will not be billed for them.* If you have questions, please consult with your insurance company prior to your appointment. You will be responsible for any charges that your insurance company determines to be non-covered.

By signing below, you acknowledge the financial terms above and agree to pay LSHC for the Travel Clinic consultation as well as any balance remaining after insurance processes charges (including those determined to be non-covered). If you are an employee, you agree to allow LSHC to transfer any remaining balance to your Banner account (office visit fee, copay, coinsurance, deductible, non-covered charges). During the appointment check-in process, each employee will sign an additional document indicating LSHC has permission to transfer balances (copay, coinsurance, deductible, and any non-covered charges) to Banner.

Name (print)__________________________________Signature ______________________________

Date:________/_____/_______ Phone (______) _________________________

Health History

____

Last Name First Middle Date of Birth

(CIRCLE AND/OR FILL IN THE APPROPRIATE BLANK)

FAMILY HISTORY

Relationship	Age	Health (Good, Fair, Poor)	Occupation	Age at Death	Cause of Death
Father		**G F P**			
Mother		**G F P**			
Brother		**G F P**			
Sister		**G F P**			
Brother		**G F P**			
Sister		**G F P**			

FAMILY ILLNESS

Disease	Grandparent	Parent	Brother	Sister	Other
Diabetes Mellitus					
Kidney Disorders					
Heart Disease (Before age 65)					
Asthma					
Cancer					
High Blood Pressure					
Other Heritable Disorders					

SOCIAL HISTORY

Alcohol Usage (circle one)

Never 1/year 1/month 1/week 1/day

Drug Use: (circle one)

Yes No

Seatbelts: I use seatbelts_______% of the time while riding or driving.

Helmets: I use helmets________% of the time while skating, cycles, or ATVs.

Exercise: I exercise enough to sweat and breathe hard______times/week

Tobacco Usage

________I don't smoke, dip or chew.

I smoke___________cigarettes/day for______years.

______pipes/day for________years.

______cigars/day for________years

I dip________cans/week for________years.

I chew________pouches/week for________years.

I quit________years ago.

REVIEW OF SYSTEMS (check those which apply to you)

Nervous System

______Bulimia or Anorexia

______Head Trauma (concussion)

______Headaches

______Depression

______Other

Infectious Diseases

______Chicken Pox

______Mononucleosis

Cardiovascular System

______High Blood Pressure

Reproductive System

Last Pap Smear:

Operative Procedures

______Tonsillectomy

______Adenoidectomy

______Appendectomy

______Wisdom Teeth Extractions

______Hernia Repair

______Knee Surgery, Left or Right

______Other

Patient Demographic Information

Name: ______________________________ Date of Birth________________________________

MSU ID: _____________________________ Net ID: ___________

Address:

____

Street/P.O. Box City State Zip

Cell Phone: (____) _____-_________ Home Phone: (____) _____-_________

Sex: __________ Race: __________

Marital Status: Single Married Divorced

Place of Employment: ____

Insurance

Check Here If No Insurance: ___________

Insurance Company Name: _______________________________

Mailing Address:

____

(on back of card) Street/P.O. Box City State
Zip Code

Insurance ID Number:____________________________________Group Number: ____________________

Insurance Policy Holder (Person Who Owns Policy)

Name:____ Circle One: Male Female

Address:

____

Street City State Zip Code

Date of Birth:_____/_____/______Cell Phone: (______)_____________Work Phone: (_____) ______________

Relationship to Patient: Self Spouse Parent Employer/School

____

Emergency Contact

Last Name:__________________First Name:_______________________Relationship:

____

Cell Phone: (________)_________________________Work Phone: (_________) _____________________

Estimated Vaccination and Medication Charges

*Updated as of 03/12/2026

Item Description	Item Billing Code	Charge Amount	Notes
Travel Clinic office visit	99402	$75	
Immunization Administration	90471	$30	
Immun. Admin. Each additional	90472	$20	
Hepatitis A	90632	$105	Series of 2
Hepatitis B	90739	$190	Series of 2
HPV	90651	$375	Series of 3
Influenza	90656	$25	
Malaria - pharmacy purchase	Pharmacy	Up to $200 - qty	
Meningococcal (MenQuadFi)	90619	$215	
MMR (Measles/Mumps/Rubella	90707	$115	Series of 2
Pneumovax 23	90732	$131	
Rabies – pt bill only	90675	$460	Series of 3
Shingles	90750	$250	Series of 2
Tdap	90715	$60	
Typhoid	90691	$180	Pt bill only
Twin Rix (HepA/B)	90636	$160	
Varicella (chicken pox)	90716	$225	Series of 2
Yellow Fever	90717	$280	Pt bill only