



**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*. Preventive Rabies vaccinations (prophylaxis) are also not billed to insurance. 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

<b>Item Description</b>	<b>Item Billing Code</b>	<b>Charge Amount</b>	<b>Notes</b>
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 – Pt bill only
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 – pt bill only	90717	\$280	Pt bill only