

TRAVEL IMMUNIZATION REQUEST

Section I: To Be Completed by Traveler

Traveler's Name: _____ SSN# _____
(Last 4 digits only)
Institute: _____ Bldg/Rm: _____ Office Phone: _____
Purpose of Travel: _____ Work related* Fax No.: _____
Have you previously visited OMS Yes _____ No _____
Approximate date of last OMS visit? _____(mm/dd/yy)

(*Please note: Employees must provide copy of NIH Travel Orders for work related immunization requests. Bring in copy at the time of your first visit.)

Last day at NIH prior to departure: _____mm/dd/yy)

Itinerary: List countries in chronological order and specify city or rural areas, any work related side trips (jungle, rivers, etc.)

Country (ies) _____ Dates: _____

SECTION II: Must Be Completed by Traveler

Allergies (Drugs and Foods): _____

Current Medical Problems: _____

Current Medications: _____

Immunization History

Type: _____ Date: _____

Name and telephone # of your personal Physician: _____

Section III: To be completed by female travelers only:

Date of last menstrual period: _____

Are you currently pregnant? _____ Yes _____ No

Are you currently breastfeeding? _____ Yes _____ No

Traveler's Signature: _____ Date _____

OMS RN Signature _____ Date _____

OMS MD Signature _____ Date _____