CHILDREN'S MEDICAL CLINIC
OF SANTA BARBARA, INC.

Pre-Travel Consultation Form

(One Form Per Patient)

Please fill this out and **fax (805-965-8905)** or mail (15 E. Arrellaga St, Santa Barbara, Ca, 93101) to our office *BEFORE* scheduling your appointment. When you come in for your appointment, your physician will have reviewed this and will be prepared to give you the up-to-date, personalized information you will need to have a safe and healthy trip. At the time of your appointment, please remember to bring a copy of your **itinerary**, and your **yellow immunization card** (if your child has received their vaccines from Children's Medical Clinic, we will have a record of those vaccines in our chart and provide you with a copy). If you have any questions, please call our office at 805-965-1095.

Today's Date: _____

_____ _____
Patient's Name: (Last, First, Middle Initial) Date of Birth

_____ _____
Primary Phone Number Other Number

Was the traveler born in the U.S.? ☐ Yes ☐ No, then where were they born? _____

Dates of Travel: _____

Destinations (List in Order) ***SPECIFY** Areas* (Providence, City/Town, etc.)	**Duration of Stay (at each destination)**	**Rural or Urban?**
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Purpose of Travel: ☐ Family Trip ☐ Visiting Family/Friends ☐ Business
☐ School Trip ☐ Aid Work/Mission ☐ Other _____

Style of Travel: ☐ Resort/Hotel ☐ Staying with Family/Friends
☐ Camping ☐ Other _____

Types of Accommodation: ☐ Hotels ☐ Hostels ☐ Home of Family/Friends
☐ Vacation Home ☐ Camping (Tents) ☐ Other _____

Activities: Please list activities you have planned (or think you may do) during your trip. Examples: scuba diving, caving, high altitude hiking, etc. Will you have contact with animals (safari, zoo, trekking, animal research?)

_____
_____

Health Conditions: Please list any health conditions or issues.

_____
_____

Medications: Please list all current medications.

_____
_____

Allergies: Please list all allergies. (Especially allergies to eggs)

_____
_____

Previous Vaccination History: Please list vaccinations or immunizations, and dates received, **if not done at Children's Medical Clinic** (such as Yellow Fever or Typhoid). Your yellow immunization card should have this information. Please indicate if there has been any reaction to a vaccine.

_____
_____

OFFICE USE ONLY: **UTD ON USUAL VACCINES:** ☐ **YES** ☐ **NO**

DATE: _____ **REVIEWED BY:** _____ **APPOINTMENT NEEDED:** ☐ **YES** ☐ **NO**