

Auburn University Montgomery
Warhawk Health Services
Travel Health History

Name: JAVAR FARRIS DOB: 08/23/2000
Address: 187 Laurel Hill Drive
Phone: 834-822-6088

1. **Travel Itinerary:** List **ALL** countries you might visit in order of travel. Include layovers IF in South America, Africa, or Panama.

Arrival Date	Country (list ALL you may visit)	City/Region	Departure Date from area
3/4/2023	Panama	City, Panama	3/11/2023

Return date to the United States:

Reason for travel: ☐ Study abroad ☒ Medical/Dental work with patient contact ☐ Vacation ☐
Conference ☐ Business ☐ Visit family/friends ☐ Other:

2. **Immunization History (with dates)**

Tetanus (most recent): Tdap <u>2011</u> Td	Varicella: 1: <u>2002</u> 2: <u>2008</u>
MMR: 1: <u>2002</u> 2: <u>2004</u>	Pneumococcal:
Hepatitis B: 1: <u>00</u> 2: <u>01</u> 3: <u>02</u> 4: <u>08</u> 5: <u>11/2</u>	Influenza (most recent):
Hepatitis A: 1: <u>2008</u> 2: <u>2011</u>	Typhoid (most recent): Injection: Oral:
Polio: <u>11/00, 1/01, 4/17/02, 8/25/04</u>	Yellow Fever:
Meningococcal (MenACWY):	COVID: Brand: Date:

3. **Risk assessment: Please check all that apply.** ☐ Work with animals ☐ Visit/work near swamps, rice, or pig farms ☐ Rural areas ☐ Urban areas ONLY ☐ Camp/hike ☐ Stay with local family ☐ High altitude (over 8,000ft)

Accommodations: ☒ Hotel with air conditioning ☐ Hotels with screening ☐ Local housing/apartment ☐ Tent ☐ Unknown

4. **Medical Conditions: check all that apply.**

☐ Heart Problems	☐ HIV/AIDS	☐ Sickle Cell Anemia
☐ Seizure Disorder	☐ Cancer	☐ Splenectomy
☐ Diabetes	☐ Receiving Chemotherapy/Radiation	☐ Thymus Disorders: Myasthenia Gravis, DiGeorge Syndrome, Thymoma, Thymectomy
☐ Severe Headaches	☐ Immune Deficiency	☒ Gastrointestinal Disease <u>IBS/GERD</u>
☐ Kidney Disease	☐ Transplant Recipient	☐ COPD or Asthma
☐ Cirrhosis of the Liver	☐ Psychiatric Disorder	☐ Tuberculosis

Medical Conditions not listed above: _____ ☒ None

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5. Allergies/reactions to medications, vaccines, food, and/or insects: None6. Medications (including supplements and OTC medications): Viberzi, Pantoprazole, Iron

For Females Only

7. Date of your last period: 1/10/2023 Have you had a hysterectomy? ☐ Yes ☒ No8. Are you currently pregnant? ☐ Yes ☒ No9. Do you plan to become pregnant in the next 3 months? ☐ Yes ☒ No10. Are you breastfeeding? ☐ Yes ☒ No

Travel Advise/ Risks Discussed

Risk/Advice	Yes	No	N/A	Risk/Advice	Yes	No	N/A
Bite Avoidance	☒	☐	☐	Sun Protection	☒	☐	☐
Food/Water Hygiene	☒	☐	☐	Bodily Fluid Infections	☒	☐	☐
Blood Borne Viruses	☒	☐	☐	Traveler's Diarrhea	☒	☐	☐
Rabies	☒	☐	☐	Other:	☐	☐	☐

For chronic conditions, I will check with my physician to discuss my care during travel, how to handle a worsening of symptoms, and if I should avoid specific vaccines. I read the CDC recommendations for my itinerary and relevant topics at [cdc.gov/travel](https://www.cdc.gov/travel) and the CDC Traveler Information Center.

Signature: Janal Farris Date: 1/17/2023

Reviewed by:

J. B. Minton, CRNP

Date:

1/17/2023

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e. g. my insurance company)
- The day-to-day healthcare operations of your practice

I have also been informed of and given the right to review and secure a copy of your Summary of the HIPAA Privacy Rule, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree with these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

General Consent for Treatment

I request and authorize health care services by my provider and his/her designees(s) as my provider may deem advisable and in my best interest. This may include routine diagnostic, laboratory procedures, and administration.

I understand that excluding emergency or extraordinary circumstances, no substantial procedure will be performed without providing me an opportunity to give me informed consent for that procedure. Informed consent means that the medical provider must disclose information to me including benefits and risks of a particular procedure and/or treatment.

Payment

I am responsible for all bills incurred at the Student Health Center. Payment is due at the time that services are rendered unless prior arrangements have been made.

I have read the consent form, or it has been read to me, and I am satisfied that I understand its contents. My questions have been answered to my satisfaction.

Signature: Jamal Farris Date: 1/17/2023
Print Patient's Name: JAMAL FARRIS
Relationship to Patient (if you are the patient, write "self"): Self

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME Javale Farris
DATE OF BIRTH 08 / 23 / 2000
month day year

For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	yes	no	don't know
1. Are you sick today?	☐	☒	☐
2. Do you have allergies to medications, food, a vaccine component, or latex?	☐	☒	☐
3. Have you ever had a serious reaction after receiving a vaccination?	☐	☒	☐
4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder?	☐	☒	☐
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☒	☐
6. In the past 3 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?	☐	☒	☐
7. Have you had a seizure or a brain or other nervous system problem?	☐	☒	☐
8. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☒	☐
9. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☒	☐
10. Have you received any vaccinations in the past 4 weeks?	☐	☒	☐

FORM COMPLETED BY Javale Farris DATE 11/17/2023
FORM REVIEWED BY [Signature] DATE 11/17/23

Did you bring your immunization record card with you? yes ☒ no ☐

It is important for you to have a personal record of your vaccinations. If you don't have a personal record, ask your healthcare provider to give you one. Keep this record in a safe place and bring it with you every time you seek medical care. Make sure your healthcare provider records all your vaccinations on it.