Occupational Health Centers

Thank you for your interest in our travel program. Once you've completed the questionnaire, please return it to us so we may process your request. Once our doctor has analyzed the information, we will contact you with this recommendation(s) for immunizations.

Please be aware that this service is **FEE-AT-TIME-OF-SERVICE**. We accept credit cards, personal checks, and cash only.

1650 Lee Lane
Beloit, WI 53511
(608) 364-4666
(608) 364-4670 - Fax

Patient Information

Last Name	First Name	Middle Initial	Company Name		Dept #
Address: Street	Apt. No.	City	State	Zip	Have you used our travel service before? Yes/No
Home Telephone	Work Telephone	Birth date	Sex	Todays Date	Marital Status S ☐ M ☐ D ☐ W ☐
SS #	Height	Weight	Spouse's Name		Phone Number
Person to Contact In Case of Emergency - Relationship - Phone Number					How Did You Hear of Us?

CURRENT TRAVEL ITINERARY IN SEQUENCE:

Date of Departure: _____ Date of Return: _____

Tourist _____ Missionary _____

Student _____ Studying What _____

Work _____ Type of Work and Area Will Be Working In: _____

_____

_____

EXACT LOCATIONS:

	Country, Providence or State (Urban or Rural?)	Contact W/Animals	Length of Stay (Days)
1.	_____	Yes/No	_____
2.	_____	Yes/No	_____
3.	_____	Yes/No	_____
4.	_____	Yes/No	_____
5.	_____	Yes/No	_____

Return To:

☐ Beloit Occupational Health
1650 Lee Lane
Beloit, WI 53511
(608) 364-4666
(608) 364-4670 - fax

☐ Janesville Occupational Health
1321 Creston Park Drive
Janesville, WI 53545
(608) 757-1217
(608) 755-1790 - fax

☐ Darien Occupational Health
300 North Walworth
Darien, WI 53114
(262) 882-1151
(262) 296 -1195 - fax

Yes	No	
☐	☐	1. Do you understand that you are responsible for an office fee on the first visit, plus the cost of each vaccine. Payment by check, cash, or credit card. We are unable to bill insurance.
☐	☐	2. Do you understand if this form is sent to the doctor and you cancel your trip or decide not to use our service you are charged $15?
☐	☐	3. Do you have any known allergies? (If so list) _____ _____
☐	☐	4. Are allergic to eggs, chicken, chicken feathers, horses, dust pollen, rag weed?
☐	☐	5. Do you have milk intolerance?
☐	☐	6. Are you pregnant, suspect you might be, plan to become pregnant within a year?
☐	☐	7. Are you breastfeeding?
☐	☐	8. Have you had a fever in the past 48 hours?
☐	☐	9. Do you plan to take steroids (oral, cortisone, injectable) in the next 14 days, or have you taken them in the past 14 days?
☐	☐	10. Do you have any known chronic or serious illness?
☐	☐	11. Are you or anyone in your household immunosuppressed (on chemotherapy, receiving radiation, HIV infected)?
☐	☐	12. Do you have kidney disease?
☐	☐	13. Do you have heart disease or high blood pressure?
☐	☐	14. Do you have liver disease (cirrhosis, hepatitis, other)?
☐	☐	15. Do you drink alcohol? (2 or more drinks per week)
☐	☐	16. Do you have a seizure disorder?
☐	☐	17. Do you currently have diarrhea, nausea, vomiting or a history of gastrointestinal disorders? _____
☐	☐	18. Do you have psoriasis?
☐	☐	19. Do you have a known allergy to sulfa antibiotics? (i.e. Sulfa, Gantrisin, Septra, Bactrim)

WHAT CURRENT MEDICATIONS ARE YOU TAKING:

List Drug/Dose/Frequency

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

HAVE YOU EVER BEEN IMMUNIZED OR HAD THE FOLLOWING DISEASES?

	Date of Injection	Date of Disease	Update Year
Polio – Oral/Shots			
Measles (7-10 Days)			
Mumps			
Rubella (3 Days)			
Born After 1957 – Had MMR Booster Between Ages 18-35			
Tetanus			
Diphtheria			
Chicken Pox			
Cholera			
Typhoid			
Yellow Fever			
Gammaglobulin			
Hepatitis A			
Hepatitis B			
Flu Vaccine			
Japanese Encephalitis			
Lyme Disease			
Rotavirus			
Rabies			
Meningococcal			

Once you have completed the questionnaire, please click the submit button so we can process it.

Submit