MISSISSIPPI STATE UNIVERSITY

LONGEST STUDENT HEALTH CENTER
P.O. Box 6338
Mississippi State, MS 39762
P. 662.325.2431
F. 662.325.8888
E. health@msstate.edu
healthcenter.msstate.edu

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 is not covered, and *insurance will not be billed for it.* Please consult your insurance company before 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 (_____) _____

Please see pricing on the back sheet of this travel packet

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 2/17/2025

Item Description	Item Billing Code	Charge Amount	Notes
Travel Clinic office visit	99402	$75	
Immunization Administration	90471	$30	
Immun. Admin. Each additional	90472	$12	
Hepatitis A	90632	$85	Series of 2
Hepatitis B	90739	$152	Series of 2
HPV	90651	$321	Series of 3
Influenza	90686	$41	
Malaria - pharmacy purchase	Pharmacy	Up to $200- qnty	
Meningococcal B	90620	$228	
Meningococcal (MenQuadFi)	90619	$168	
MMR (Measles/Mumps/Rubella	90707	$105	Series of 2
Pneumovax 23	90732	$131	
Rabies	90675	$460	Series of 3
Shingles	90750	$198	Series of 2
Tdap	90715	$49	
Typhoid	90691	$145	
Twin Rix (HepA/B)	90636	$129	
Varicella (chicken pox)	90716	$209	Series of 2
Yellow Fever	90717	$225	Pt bill only