

**FAIRFAX COUNTY HEALTH DEPARTMENT
INTERNATIONAL TRAVEL CLINIC**

NAME: _____ AGE: _____ TODAY'S DATE: _____
 LAST FIRST

DATE OF DEPARTURE: _____ HOW LONG WILL YOU BE GONE? _____

ITINERARY (List countries to be visited in order and length of stay in each): _____

PURPOSE OF TRIP (circle): Business Mission Student Tourist Visit Family/Friends Other: _____

TRAVEL PLANS: (circle all that apply):

Camping	Construction	Cruise Ship	High altitude	Hiking
Host family	Hostel	Hotel-small	Hotel – large resort	Medical team
Rural travel	Safari	Other:		

**DO NOT WRITE BELOW THIS LINE
TRAVEL VACCINATION / MEDICATION PLAN
This does not take the place of an Official Record of Vaccines**

DATE	DISEASE/ VACCINE	DURATION OF PROTECTION	DATE	DISEASE/ VACCINE	DURATION OF PROTECTION
	Flu	1 year		Meningococcal Meningitis	3-5 years
	Hepatitis A <i>Series of 2</i>	Lifetime		Polio: IPV	Lifetime, after booster
	Hepatitis B <i>Series of 3</i>	Lifetime		Rabies <i>Series of 3</i>	Booster only for high risk
	Immune/Gamma Globulin <i>For prevention of Hepatitis A</i>	3 months		Tetanus Diphtheria (Td) or Tetanus , Diphtheria, Pertussis (Tdap)	10 years
	Japanese Encephalitis <i>Series of 2</i>	1 year Booster only once if needed		Typhoid: Injectable ViCPS <i>(Must be at least 2 years old)</i>	2 years
	Malaria	Per trip		Typhoid: Oral <i>(Must be a least 6 years old)</i>	5 years
	Measles, Mumps, Rubella (MMR) <i>Series of 2</i>	Lifetime		Yellow Fever	10 years or Lifetime

RETURN DATE	VACCINE NEEDED

COMMENTS: _____
