Pre-Travel Survey for Group Vanderbilt Business Travel

Section 1: To be completed by supervisor – return this to OHC when complete. OHC will copy Section 1 to be used for each Traveler. Traveler completes section 2 and then submits to OHC to book a pre-travel consultation. Documents may be submitted by Secure File Transfer to occupational.health.clinic@vanderbilt.edu

Department(s): _____________________________________________________________

Name of Department Contact/Travel Coordinator for group: __________________________

Please list Traveler’s Names below or attach as a separate list (Vanderbilt faculty/staff only)

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1. Destination(s) (city and country)  Arrival Date  Departure Date  Purpose of trip

- □ Conference, meeting, interview or lecture
- □ Research  □ Providing medical care
- □ Other: ____________________________

2. What is the work status for the travelers while abroad? If one status does not cover all travelers please indicate the status for each on the list of names.

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<td>Working for Vanderbilt</td>
<td>On Personal Time (Unpaid)</td>
<td>On Vacation</td>
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3. Will traveler be providing medical care at a rural, remote, primitive or inaccessible location, without immediate access to evaluation and medication in the event of a needlestick?

- □ No
- □ Yes. OHC will provide a prescription for post exposure prophylactic HIV medication for the traveler. List names of at least two persons who will carry the PEP meds: ____________________________.

Please provide an 1180 form for each traveler who will carry PEP meds. The travelers will take this to the pharmacy with and OHC prescription to cover the cost of the medication. Each 3 day kit costs approximately $100. For an exposure requiring extended post exposure treatment, evacuation may be necessary.

4. Advise the employees that international business travelers must register their itineraries with International SOS at www.vanderbilt.edu/vio.

5. Some destinations are excluded from Vanderbilt’s usual workers compensation coverage. For destinations with a state department travel warning, contact Risk Management to arrange additional coverage if needed. Current travel warnings are posted at http://travel.state.gov

- □ No travel warning for this destination
- □ Travel warning is in effect – I have called Risk Management or will do so prior to trip

Supervisor’s Name and Title: ____________________________________________

Supervisor’s Signature: __________________________ Date: __________

Your Occupational Health Clinic pre-travel consultation may be scheduled after this survey has been submitted to OHC. Occupational Health provides pre-travel consultations and immunizations as a benefit for faculty/staff on Vanderbilt business travel. Travelers using vacation, leave, or unpaid personal time may obtain a pre-travel consultation through the Vanderbilt Travel Clinic at 936-1174. Vanderbilt students may obtain pre-travel care through Student Health.
Pre-Travel Survey for Group Vanderbilt Business Travel

Section 2: To be completed by traveler – do not give this information to your supervisor

Name: ______________________________ Employee ID: _________________
Date of Birth: ________________________ Country of Birth_______________
E-mail address________________________ Phone_______________________

Trip Itinerary
Departure date: _______________ Return date or length of stay: ________________
List all countries that you will visit in the order of travel:
1. ________________________
2. ________________________
3. ________________________
4. ________________________
5. ________________________
6. ________________________

Have you previously traveled to this destination? Yes___ No___
Have you registered this trip with International SOS at www.vanderbilt.edu/vio? Yes___ No___

Vaccination History (list dates of vaccine)
Tetanus: Td ___________ or Tdap ___________ (date of latest tetanus vaccine only)
MMR: #1___________ #2___________ #3___________
Hepatitis B #1___________ #2___________ #3___________
Hepatitis A #1___________ #2___________
Polio Booster ___________
Typhoid: Oral(live)________ or Injectable (inactivated)________
Rabies #1___________ #2___________ #3___________ #4___________ #5___________
Meningitis ___________
Varicella #1___________ #2___________
Japanese Encephalitis ___________
Yellow Fever ___________
Influenza ___________
Pneumonia ___________
Other vaccines________________________________________________________

Previous Malaria prophylaxis Yes___ No___
Malaria medication reactions Yes___ No___

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Health Assessment
Check any of the following that apply to you:

- Immunity or immune suppression
- Spleen removal
- Transplant recipient
- Cancer/chemotherapy
- HIV
- Steroid medication use
- Depression/Panic attack/Anxiety
- Psoriasis
- Seizures
- Thymus disease/thymus surgery
- Cardiac conduction defect (irregular heart beat)
- Heart disease
- Lung disease
- Kidney disease or frequent Urinary Tract Infections
- Liver disease
- Musculoskeletal problems
- Gastrointestinal problems
  (Crohn’s, ulcerative colitis, irritable bowel)
- Diabetes
- Blood transfusion within the last year
- Altitude problem-mountain sickness
- Have been ill or had a fever in the past 3 days

Describe all “checked” responses:

List all current medications:

List all allergies (egg, bees, medications, foods)

Women – LMP _____ Risk of pregnancy? Yes_____ No______ Pregnant_____ weeks
Breast Feeding? Yes_____No______

Trip Risk Assessment
Solo traveler? Yes_____ No______ If no, name of group leader/organizer: ___________________
Will you be visiting friends or relatives? Yes_____ No ______
Lodging:
  Urban - Hotel Class 5____ Hotel Class #_____ Local apartment______
  Live with locals / private home_____
  Rural - Remote location______ Tents/travel camper_______
Occupational exposures:
  Healthcare work______ Animal research______ Other_____________________
Recreational activities:
  Cruise _____ Safari _____ Trekking _____ Surfing _____ Diving _____
  Rafting _____ Spelunking _____ Biking _____ Camping _____ Other _____
  Contact with animals (dogs or farm animals) ________

Insurance Coverage
Vanderbilt Blue Cross___ Vanderbilt Aetna___ Other___ Extra travel medical insurance ___

Traveler’s Signature: ___________________________________  Date: _________________________

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