**Berkeley Morgan County Health Department Travel History Form**

Please complete the following form and scan/email, fax, or drop off to the health department. Scan forms to: [tmanley@berkeleywv.org](mailto:tmanley@berkeleywv.org) or Fax forms to: 304-263-1067. Travel vaccination appointments will not be scheduled until form has been received and reviewed by the health department staff.

|  |  |
| --- | --- |
| Name: |  |
| Date of Birth: |  |
| Age: |  |
| Address: |  |
| Phone #: |  |
| Email Address: |  |
| Patient Pharmacy |  |
| Date of Travel Departure: |  |
| Date of Travel Return: |  |
| Where staying: |  |
| Purpose of Travel: (vacation, mission, etc) |  |
| Allergies: |  |
| Primary Care Provider/Telephone # |  |
| Are you Pregnant: | YES NO NA  (please circle) |
| Are you Breastfeeding: | YES NO NA  (please circle) |

**Planned Itinerary:**

|  |  |
| --- | --- |
| 1st Destination: |  |
| 2nd Destination: |  |
| Additional Destinations: |  |
| Flight Stops: |  |

**Immunization History (please provide dates or attach immunization record):**

|  |  |
| --- | --- |
| Tetanus/Diphtheria/Pertussis (TD or TDaP) |  |
| Polio (IPV or OPV) |  |
| Measles/Mumps/Rubella (MMR) |  |
| Hepatitis A |  |
| Hepatitis B |  |
| Meningitis |  |
| Pneumonia |  |
| Influenza |  |
| COVID |  |
| Japanese Encephalitis |  |
| Typhoid (oral or injectable) |  |
| Yellow Fever |  |

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |
| --- | --- | --- | --- |
| **Medical Condition** | **YES** | **NO** | **Comments** |
| Lung Disease, Bronchitis, Pneumonia, Asthma |  |  |  |
| Cardiovascular Problems |  |  |  |
| Diabetes |  |  |  |
| Seizures |  |  |  |
| Circulatory Problems |  |  |  |
| GI symptoms |  |  |  |
| Genito-Urinary Problems |  |  |  |
| Other: |  |  |  |

|  |  |  |
| --- | --- | --- |
| **Medication Name** | **Dose** | Frequency |
|  |  |  |
|  |  |  |
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**Berkeley Morgan County Health Department**

**Travel Clinic Cost Information**

Payment for travel consultation is expected day of appointment and if vaccine administration is expected at the same appointment vaccine payment must be received. For patients using credit/debit cards for transactions, a 2% (plus $1.00) service fee will be added to your original charge/fee. Patient can submit to insurance companies for reimbursement of vaccines but insurance companies usually do not cover travel consultation or travel vaccinations.

|  |  |
| --- | --- |
| Travel Consultation Fee: | $75.00 (not billable to insurance) |
| Administration Fee (per injection): | $20.00 |
| Hepatitis A (Adult): | $89.00 per injection (series of 2) |
| Hepatitis A (Pediatric): | $37.00 per injection (series of 2) |
| Hepatitis B (Adult): | $60.00 per injection (series of 3) |
| Hepatitis B (Pediatric): | $22.00 per injection (series of 3) |
| Polio (IPV): | $52.00 |
| Japanese Encephalitis: | $460.00 |
| Meningococcal: | $177.00 |
| Meningitis B: | $237.00 |
| Measles, Mumps, Rubella (MMR): | $112.00 |
| Rabies (pre-exposure 2 dose series): | $ (price determined when ordered at time of ordering, 2 dose recommended) |
| Tetanus (TD): | $45.00 |
| Tetanus, diphtheria, pertussis (TDaP): | $56.00 |
| Typhoid (injectable): | $185.00 |
| Ticovac – Tick Borne encephalitis | $440.00 |
| Varicella (chickenpox): | $228.00 |
| Yellow Fever: | $275.00 |
| Shringix: | $258.00 |
| Flu | $25.00 |
| Fluzone High Dose | $98.00 |
| RSV | $360.00 |
| COVID- Moderna |  |

**PRICES ARE SUBJECT TO CHANGE!**

**Revised 09/2025**