APPENDIX D

Northeast Ohio Medical University
Student International Experience
HEALTH FORM

Instructions: This form must be completed by your health care provider. It is recommended that you provide your health care provider with a copy of your NEOMED Immunization Form (available from the Office of Student Services)

Student Name: _____

Leaving for: _____

Date leaving USA _____ **Date Returning to USA** _____

Need (check)	Vaccine/immunization/medication	Date Ordered	Provider/person administering	Date given
	CURRENT CDC Travel Recommendations for listed area reviewed with and given to student.			
	ALL vaccine consents are signed and witnessed.			
	mefloquine 250 mg. (Larium) Take one weekly, same day each week Start date _____ thru _____. Take for _____ weeks.			
	chloroquine 500mg. (Aralen) Take one weekly, same day each week Start date _____ thru _____. Take for _____ weeks.			
	Hepatitis A Vaccine. (2 weeks before travel) One adult dose, 1 ml., IM, deltoid area.			
	Typhim VI. (2 weeks before travel) One adult dose, 0.5 ml IM, deltoid area.			
	Oral Typhoid vaccine (Vivotif Berna) One package, as directed, p.o.			
	Inactivated polio vaccine (IPV). One adult dose, 0.5 ml IM or SC, deltoid area.			
	Tetanus-diphtheria booster. One adult dose, 0.5 ml IM, deltoid area.			

	Rabies vaccine. (3 doses) Give 0.1 ml intradermal on Day 1,7, and 21 or 28.			
	Positive Hepatitis B surface antibody			
	Meningococcal vaccine. Give 0.5 ml SC.			
	Cipro 500 mg, p.o., bid, for severe traveler's diarrhea x 5-7 days.			
	Yellow fever vaccine.			
(additions)				

NOTE: This record is verification that the student has completed all health requirements for international travel to location listed above.

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Signature of health provider (include clinic stamp)