Immunization/Travel Clinic

1675 W. Garden of the Gods Rd., Suite 2044
Colorado Springs, CO 80907
(719) 578-3199 *phone*
(719) 575-3192 *fax*
www.elpasocountyhealth.org

Prevent • Promote • Protect

Travel Clinic Confirmation/ Essential Information

Dear Traveler(s),

During your visit you will be seen by a Public Health Nurse who has training and skills regarding international travel health. Some helpful information before your appointment:

- Appointments are for up to 45 minutes with a nurse. Appointment times may vary depending on complexity of travel itinerary, number of travelers, and health status.
- Please bring the following to your appointment:
    - Travel registration form (attached to this email)
    - All previous vaccination records. This could save you money as some vaccines are good for a lifetime. This is even more important for children.
    - Insurance card (for non-travel vaccines, if applicable)
- Fees: There is a $60 clinic fee for each traveler seen for a consultation, whether or not vaccinations are given. The cost of vaccines is added to the clinic fee. Our current vaccine price list is attached.
- Payment: We accept cash, check, VISA, and MasterCard.
- Insurance and third party billing: We are able to accept insurance for non-travel specific vaccines through select insurance providers. We encourage you to communicate with your insurance company regarding vaccine coverage prior to your appointment. If you have any questions regarding which providers we accept, please call (719) 578-3199, option 5.
- We are unable to bill Medicaid for travel appointments.
- Medications for malaria and traveler's diarrhea prevention: we cannot provide prescriptions for medications. You will need to contact your primary care provider for any prescriptions after your visit with us. Some destinations may not be at risk for malaria transmission.

To cancel or reschedule your appointment, call (719) 578-3199, option 5 at least 24 hours in advance. Failure to cancel your appointment 24 hours or more in advance may result in a $50 charge per patient. We can be reached by phone Monday through Friday: 8 a.m. – 12 p.m. and 1 p.m. – 4:15 p.m. We look forward to seeing you soon!

Updated 9/1/17

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Fees and Vaccine Prices for Immunizations/Travel Clinic

*__Prices subject to change related to market conditions__

(Effective: February 1, 2018)

Travel Clinic Office Visit (required for international travel consultation) *vaccine administration fees are included in the travel clinic fee	$60.00
International Certificate of Vaccination (required for yellow fever)	$5.00
Vaccine Administration Fees:	
First Vaccine	$25.00
Each Additional Vaccine	$15.00/vaccine
Vaccines:	Price per dose:
Cholera (*Vaxchora*)	$250.00
DTaP (Diphtheria, Tetanus and Pertussis/Whooping Cough)	$50.00
DTaP, Hep B, and Polio (*Pediarix)*	$100.00
DTaP and Polio (*Kinrix)*	$78.00
DTaP, Polio, and HIB (*Pentacel)*	$105.00
Hepatitis A (age 19 and over)	$85.00
Hepatitis A (age 12 months through age 18)	$50.00
Hepatitis B (age 20 and over)	$85.00
Hepatitis B (through age 19)	$50.00
Hepatitis A and B combination for ages 18 and older *(Twinrix)*	$115.00
Herpes Zoster (*Shingrix*) coming soon!	
Hib (Haemophilus Influenzae Type b)	$47.00
HPV9 (Human Papilloma Virus/*Gardasil 9*)	$215.00
Influenza (6 months through 35 months)	$35.00
Influenza (injectable quadrivalent)	$35.00
Influenza, High dose (65 & older)	$55.00
Japanese Encephalitis (*Ixiaro*)	$349.00
Meningococcal B (MenB-4C/*Bexsero*)	$180.00
Meningococcal (MCV4/ *Menveo*)	$145.00
MMR (Measles, Mumps, Rubella)	$95.00
MMRV (Measles, Mumps, Rubella, Varicella/*Proquad*)	$215.00
Pneumococcal (*Pneumovax23*)	$109.00
Pneumococcal Conjugate (*Prevnar 13*)	$215.00
Polio	$65.00
Rabies	$310.00
Rotavirus (*Rotarix)*	$135.00
Td (Tetanus and Diphtheria)	$55.00
Tdap (Tetanus, Diphtheria, and Pertussis/Whooping Cough)	$65.00
TST –Tuberculosis Skin Test	$20.00
Typhoid (injectable, *Typhim Vi*)	$95.00
Typhoid, Oral (Ty21a - 4 capsule series)	$85.00
Typhoid, Oral (single replacement capsule)	$21.25/capsule
Varicella	$150.00
Yellow Fever	$185.00

El Paso County, CO Public Health Prevent • Promote • Protect

El Paso County Public Health – International Travel Clinic
Travel Registration Form – Please complete front and back

Name: _____________________________ _____________________________
LAST FIRST

Date of Birth (mm/dd/yr):__________ **Gender** *(circle one)*: Male Female **Age:** _______

Itinerary:

Date of Departure: _____________ **Date of Return:** ______________
mm/dd/yy mm/dd/yy

List each country in order of travel (include layovers) **Length of Stay** (please specify if layover)

1. _________________________________ _______________________
2. _________________________________ _______________________
3. _________________________________ _______________________
4. _________________________________ _______________________
5. _________________________________ _______________________

Purpose of Travel: ____

Accomodations (circle all that apply):

Major hotels
Staying with family/friends/locals
Rural/small hotels
Camping/trekking/safari
Rented home
Cruise ship
Hostel/dorm

Activities (circle all that apply):

Leisure
Construction work
Refugee/aid work
Medical work
Other: ________

Travel history:

Have you traveled previously outside the U.S.? *(circle one)* Never Once Several times Extensively

List any vaccines you have received in the past for travel:

____

Health History:

List any medications you are currently taking:

____

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Health History (continued):

List any chronic physical or mental conditions you have:

____

List any allergies to medications or vaccinations:

____

Yes **No** Do you have an allergy to the following? *(circle all that apply)*

Eggs Gelatin Latex Yeast

Mercury (thimerosal) Aluminum Other: ________________

Yes **No** Are you sick today?

Yes **No** Have you ever fainted from having your blood drawn or from an injection?

Yes **No** Do you have a history of Guillian-Barre syndrome or a seizure disorder?

Yes **No** Have you ever had problems with your thymus, myasthenia gravis or DiGeorge syndrome?

Yes **No** Do you or any person you live with have an immune disorder, HIV, or receive radiation or chemotherapy treatments?

Yes **No** Have you received any injection of immune globulin or any blood products in the last 6 months?

Yes **No** Has a doctor ever recommended that you do not travel?

Yes **No** Has anyone (such as a group leader, physician, nurse) already given you a list of recommended or required vaccines or medications?

For women only:

Yes **No** Are you pregnant, suspecting you may become pregnant, or trying to become pregnant?

List any travel concerns you may have: ____

I certify that all information given is correct. I understand that my insurance may not cover travel vaccinations; therefore, I am responsible for all the fees (including the $60 travel consultation fee per traveler) associated with this visit at the time of service.

Signature of client or parent/guardian X _____________________________________

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(Name of person being vaccinated)

Last Name:____________________________ First Name:___________________________

Date of Birth (mm/dd/yr):_______________________ Age:__________ Gender: Male Female
(Circle one)

Circle one:

- **Race:** Caucasian/White, African American-Black, American Indian/Alaskan, Asian, Pacific Islander, Other
- **Ethnicity:** Hispanic or non Hispanic
- **Primary Language:** __________________________

Address:________________________________Apt #________ City ___________________________

State:_______________ Zip Code:_________ County:______________________

Phone:___________________ Alt Phone:_________________

Do you have insurance? (circle one) Y N [if no, go to next section]

If so, does your insurance cover immunizations? (circle one) Y N

CO MEDICAID #:_________________ Colorado Access/CHP+: __________________

Private Insurance Company: ________________Member ID#:______________ Group ID#:______________

Primary Policy Holder Name:__________________________ DOB:____________

(Please name consenting person(s), to include yourself, authorized to bring in child and make vaccine decisions)

Parent/Legal Guardian Name (print):____

Parent/Legal Guardian Name (print):____

Other Authorized Person (print):____

For Office Use Only

VFM VFN NE VFI CIIS/Initials_________Date_____________

Updated 9/1/17