



PEDIATRICS, P.C.

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### Foreign Travel

Name \_\_\_\_\_

Birthdate \_\_\_\_\_

Weight \_\_\_\_\_

Swallow pills? Yes \_\_\_\_\_ No \_\_\_\_\_

Medication allergies? None \_\_\_\_\_ Yes \_\_\_\_\_

Current medications:

Departure date:

Return date:

Destination(s):                      Country                      Cities or Regions

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

Area type: Large urban \_\_\_\_\_ Small town \_\_\_\_\_ Rural \_\_\_\_\_

Nature of visit: Tourism \_\_\_\_\_ Mission \_\_\_\_\_ Other \_\_\_\_\_

Group (if going with group):

Concerns reported by group leaders (if going with group):