CARE MATTERS

TRAVEL CLINIC

LAST NAME	FIRST NAME	MIDDLE NAME
PREFIX/ SUFFIX	SEX	DATE OF BIRTH *(mm/dd/yy)*
STREET ADDRESS	CITY/ STATE	ZIP CODE
HOME PHONE *(include area code)*	CELL PHONE *(include area code)*	WORK PHONE *(include area code)*

*IF FEMALE, ARE YOU PREGNANT OR PLANNING TO BECOME PREGNANT IN THE NEXT THREE MONTHS? ☐ YES ☐ NO

PLEASE CHECK ALL THAT APPLY:

☐ DISABLED ☐ CHRONIC DRUG THERAPY

☐ HEART/LUNG DISEASE ☐ EAR/ SINUS PROBLEM ☐ STINGING INSECT ALLERGY

☐ NON-IMMUNIZED ADULT ☐ EGG ALLERGY ☐ NEOMYCIN ALLERGY

☐ RABIES VACCINE ALLERGY ☐ IMMUNOCOMPROMISED ☐ OTHER:_____

HAVE YOU EVER HAD A BAD REACTION OR FAINTED WHEN YOU RECEIVED AN INJECTION?

IF YES, PLEASE EXPLAIN:_____

IMMUNIZATION HISTORY:

DID YOU COMPLETE CHILD ADOLESCENT IMMUNIZATIONS? ☐ YES ☐ NO ☐ UNKNOWN

IF YES, DATE OF LAST SHOT: _____/_____/_____

HAVE YOU RECEIVED ANY IMMUNIZATIONS OTHER THAN PRIMARY SERIES *(childhood vaccines)*?

YES NO IF YES, WHICH ONE(s):_____

MEDICAL PROBLEMS	CURRENT MEDICATIONS

LIST COUNTRIES YOU WILL VISITS ALONG WITH DATES OF DEPARTURE AND ARRIVAL *(in order of travel):*

_____ _____/_____/_____ TO _____/_____/_____

_____ _____/_____/_____ TO _____/_____/_____

_____ _____/_____/_____ TO _____/_____/_____

DATE OF DEPARTURE: _____/_____/_____ TRIP DURATION: _____

I GIVE CONSENT TO ADMINISTER THE DISCUSSED VACCINES, TAKING INTO CONSIDERATION THAT ALL VACCINES ARE NOT 100% EFFECTIVE. ALL POSSIBLE SIDE EFFECTS HAVE BEEN EXPLAINED TO ME. I WILL ALSO BE FURNISHED WITH AN ITEMIZATION OF SERVICES AT CHECK-OUT. I AM AWARE THAT THE TRAVEL CLINIC DOES NOT ACCEPT INSURANCE AND IS NOT RESPONSIBLE FOR INSURANCE REIMBURSMENTS.

SIGNATURE: _____ DATE:_____/_____/_____

NAME: _____ DOB: _____

PLANNED IMMUNIZATIONS	ADMINISTERED AT OUTSIDE FACILITY DATE	ADMINISTERED DATE	SITE	LOT #	EXP DATE	ADMINISTERED BY
HEPATITIS A			L or R			
HEPATITIS B			L or R			
TWINRIX			L or R			
BOOSTRIX			L or R			
TYPHOID ORAL						
TYPHOID Vi			L or R			
MMR			L or R			
MENOMUNE			L or R			
MENECTRA/MENVEO			L or R			
PNEUMOCCOAL			L or R			
POLIO			L or R			
RABIES			L or R			
JAPANESE ENCEPHALITIS			L or R			
VARICELLA			L or R			
ZOSTER			L or R			
INFLUENZA			L or R			
YELLOW FEVER			L or R			
HIB			L or R			
TUBERCULINE (TST)			L or R			

PRESCRIPTIONS	*#GIVEN*	*COMMENTS*
MALARONE 250MG		
MALARONE (PEDIATRIC TAB)		
DOXYCYCLINE		
CIPRO 500MG BID		
OTHER		