

You must remain in the clinic for 20 minutes following any vaccination.

Date: ___ / ___ / _____ (DD/MM/YYYY) Chart #: _____ Health insurance #: _____

PATIENT INFORMATION (To be completed by the traveller)

Vaccines, medications and other travel recommendations will be tailored to suit your needs based on your responses.

 Gender: Male Female Date of birth: ___ / ___ / _____ (DD/MM/YYYY)

Last name: _____ First name: _____

Street: _____ City: _____ Province: _____

Country: _____ Postal code: _____

Phone (Home): _____ (Work): _____ (Cell): _____

 E-mail: _____ Weight (if under 18 yrs): _____ lbs kg

In what country were you born? _____

If not in Canada, at what age did you leave your country of birth? _____

Company: _____ Job title: _____

Emergency contact: _____ Phone: _____ Relationship to you: _____

MEDICAL INFORMATION (This information will NOT be shared with your employer.)

Do you currently have a fever or an active infection? Yes No
Do you have (or have you had) any of the following medical conditions?

- | | |
|---|--|
| <input type="checkbox"/> Chronic or significant medical condition (specify) | <input type="checkbox"/> Thymus disease |
| i _____ ii _____ | <input type="checkbox"/> Inflammatory bowel disease |
| iii _____ iv _____ | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Seizures or convulsions | <input type="checkbox"/> Respiratory (lung) conditions |
| <input type="checkbox"/> Immunosuppression/impaired immune system | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Coagulation disorder |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Free from any Medical Condition |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Psoriasis | |

Are you taking any of the following medications?

- | | |
|--|---|
| <input type="checkbox"/> Anticonvulsants | <input type="checkbox"/> Anti-viral medication (HIV, other) |
| <input type="checkbox"/> Antidepressants | <input type="checkbox"/> No medication |
| <input type="checkbox"/> Anticoagulant / Warfarin / Coumadin | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Chemotherapy | _____ |
| <input type="checkbox"/> Steroids (prednisone) | _____ |
| <input type="checkbox"/> Immunosuppressive drugs | _____ |

Are you allergic to any of the following?

- | | |
|--|---|
| <input type="checkbox"/> Eggs (describe reaction): _____ | <input type="checkbox"/> Sulfa, Sulfamycin, Bactrim, Septra |
| <input type="checkbox"/> Food (describe reaction): _____ | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Wasp/Insect bites | <input type="checkbox"/> Tetracyclines |
| <input type="checkbox"/> Latex | <input type="checkbox"/> Formaldehyde or Phenol |
| <input type="checkbox"/> Thimerosal or Aluminum | <input type="checkbox"/> No allergy |
| <input type="checkbox"/> Neomycin | <input type="checkbox"/> Other: _____ |

WOMEN'S ONLY
Are you pregnant?

 Yes - # of weeks: _____

 No - Are you planning to become pregnant within 3 months? Yes No
Are you breastfeeding? Yes No
Do you have any concern(s) regarding your period while on this trip? Yes No

ITINERARY Departure date: ___ / ___ / _____ (DD/MM/YYYY) Duration of trip: ___ days ___ weeks ___ months

Please, list all countries and regions you will visit (including stop over) during your trip

	Countries to be visited	Urban areas/Duration	Rural areas/Duration
1			
2			
3			
4			
5			
6			
7			
8			
9			

Purpose of trip:

- | | | |
|--|--|--|
| <input type="checkbox"/> Pleasure/holiday | <input type="checkbox"/> Education/study/summer camp | <input type="checkbox"/> Business (specify type of work) |
| <input type="checkbox"/> Visiting family/friends | <input type="checkbox"/> Volunteer work | _____ |
| <input type="checkbox"/> Adoption | <input type="checkbox"/> Religious visit | <input type="checkbox"/> Other: _____ |

Where will you be staying?

- | | | |
|--|---|---------------------------------------|
| <input type="checkbox"/> 1 st class hotel, resorts or cruise ship | <input type="checkbox"/> Camping | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Budget hotels and/or hostels | <input type="checkbox"/> Company lodge | |
| <input type="checkbox"/> Inns / B&B | <input type="checkbox"/> Family/friends | |

Possible activities:

- | | | |
|--|---|--|
| <input type="checkbox"/> Healthcare activities | <input type="checkbox"/> Wilderness activities/extreme sports | <input type="checkbox"/> Safari |
| <input type="checkbox"/> Volunteer/humanitarian activities | <input type="checkbox"/> High altitude activities/climbing | <input type="checkbox"/> Jogging, running, bicycling |
| <input type="checkbox"/> Activities involving contact with animals | <input type="checkbox"/> Rafting/water sports | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Veterinary activities | <input type="checkbox"/> Underwater diving | _____ |

IMMUNIZATION HISTORY

I have not had any vaccinations in the past 10 years

<u>Vaccine</u>	<u>Date of Last Dose</u>	<u>Vaccine</u>	<u>Date of Last Dose</u>
<input type="checkbox"/> Cholera (Dukoral)	_____	<input type="checkbox"/> MMR	_____
<input type="checkbox"/> DT (Diphtheria/ Tetanus)	_____	<input type="checkbox"/> Polio	_____
<input type="checkbox"/> DTaP (Adacel)	_____	<input type="checkbox"/> Pneumococcal	_____
<input type="checkbox"/> DTP (Dipht./Tet./Polio)	_____	<input type="checkbox"/> Rabies	_____
<input type="checkbox"/> Hepatitis A	_____	<input type="checkbox"/> TBE vaccine	_____
<input type="checkbox"/> Hepatitis B	_____	<input type="checkbox"/> Typhoid fever	_____
<input type="checkbox"/> Hepatitis A&B combo	_____	<input type="checkbox"/> Yellow fever	_____
<input type="checkbox"/> Hepatitis A/Typhoid combo	_____	<input type="checkbox"/> Zoster (shingles)	_____
<input type="checkbox"/> HPV (Gardasil, Cervarix)	_____	<input type="checkbox"/> Other: _____	_____
<input type="checkbox"/> Influenza	_____	<input type="checkbox"/> Other: _____	_____
<input type="checkbox"/> Japanese encephalitis	_____		
<input type="checkbox"/> Mantoux test	_____		
<input type="checkbox"/> Meningitis	_____		

Have you ever had an adverse reaction to a vaccine?

Please specify: _____

I declare that all the information provided on this form is accurate to the best of my knowledge and I understand that any false information could be detrimental to my health.

Signature: _____ Date: ___ / ___ / _____ (DD/MM/YYYY)

Note: Most vaccines are generally well tolerated; however, you may experience some soreness, redness and swelling at the injection site. Other adverse reactions may include headaches, fever, fatigue, and muscle pain. As with any vaccine, an allergic reaction or anaphylactic response could occur.