Carolina Travel Care &
Vaccination Center
Non-Travel Vaccine Health History / Consent

Name: ______________________________ Date: ______________

Address: ______________________City: ____________State: ______ZIP: ________

Home Phone: ______________Cell: ______________Work: ______________

Birthdate: ____________ Age: __________ Sex: ( ) M ( ) F Weight if < 100 lbs________

Email address: ______________________________

Employer: ______________________ Occupation: ______________________

Referred By: ( ) Physician______________ ( ) Website______________

( ) Health Dept. ( ) Friend ( ) Other______________________

Vaccine(s) Requested: ______________________ **Reason:** ______________________

______________________ ______________________

Prior Immunization History

Please bring any records of prior immunizations received in the past, including childhood vaccines if available. If you have an <u>International Certificate of Vaccination</u> (yellow card) from prior travel, please bring it with you.

***Document date of most recent immunization for the vaccines listed below.**
(For those that require a multi-dose series, please notify us if you did complete the full series of injections.)

Vaccine	Date*	Vaccine	Date*
Tetanus/diphtheria (Td)		Yellow Fever	
Tetanus/diphtheria/acellular pertussis (Tdap)		Measles/mumps/rubella (MMR) - [2 shots]	
Hepatitis A - [2 shots]		Varicella (chicken pox) – [2 shots]	
Hepatitis B - [3 shots]		Influenza (Flu)	
Hepatitis A+B – [3-4 shots]		Polio – [3-4 shots]	
Typhoid (injection – TyphimVi)		Rabies – [3-5 shots]	
Typhoid (oral – 4 doses)		Japanese Encephalitis – [4 shots]	
Meningococcal conjugate (Menactra) Meningococcal polysaccharide (Menomune)		Pneumococcal polysaccharide (Pneumovax) Pneumococcal conjugate (Prevnar)	

Have you had an adverse reaction to any of the above? (circle) Yes No
If yes, describe vaccine and reaction:______________________________

Are you allergic to: Eggs? Yes No Bee stings? Yes No Thimerisol? Yes No

List any other allergies (including medications, foods, latex etc.):______________________

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Medical History & Medications

Do you have any history of the following?

High blood pressure?	Yes	No	Heart problems / irregular heart rhythm?	Yes	No
Seizures / epilepsy?	Yes	No	Depression / psychiatric disorder?	Yes	No
Diabetes?	Yes	No	Tuberculosis or + TB skin test?	Yes	No
Hepatitis?	Yes	No	Bleeding disorder or blood thinners?	Yes	No

Do you have any problems with your immune system? (eg. HIV, Leukemia/lymphoma, spleen removed, on chemotherapy or radiation treatments for cancer, on prednisone/steroids, organ transplant)
Yes No

Do you live with anyone who has a weakened immune system? Yes No

List any other medical conditions you have:____

<u>For women only</u>: Are you pregnant or planning to become pregnant in the next three months? Yes No

<u>List all medications</u> you currently take. (include birth control, inhalers and any over-the-counter medications):____________
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Notes: (office use only)

The above information is accurate to the best of my knowledge. I understand that insurance may not cover travel immunization services and I am responsible for all fees associated with the visit. Carolina Travel Care is not a Medicare provider and does no insurance billing or filing of claims. Payment is due at the time of service by cash, check or credit card.

Traveler /parent/guardian signature:____ **Date:**_________________

Print name:____