

**Carolina Travel Care &
Vaccination Center**
International Travel 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 _____

Previous International Travel

1. Country/year	4. Country/year
2. Country/year	5. Country/year
3. Country/year	6. Country/year

Planned Travel Itinerary

List countries in order of visit and indicate “U” if visiting urban areas or “R” if visiting rural areas, or “B” for both. Please be as specific as you can regarding areas of travel and depth of interaction with local inhabitants and food / water sources.

Country – give specific region /area	Arrival Date	Duration of stay	Rural / Urban	Consuming local food / water? If yes, describe.

Purpose(s) of travel (check all that apply):

Business Vacation Study / Field work Missionary work Other: _____
Medical mission? Y / N

Accommodations:

Hotel Private Home Camping Youth hostel Mission compound
Describe: _____

Prior Immunization History

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

*Document date of most recent immunization for the vaccines listed below.

<u>Vaccine</u>	<u>Date*</u>	<u>Vaccine</u>	<u>Date*</u>
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)		Pneumococcal polysaccharide (Pneumovax)	
Meningococcal polysaccharide (Menomune)		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.): _____

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: _____

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

List all medications you currently take. (include birth control, inhalers and any over-the-counter medications): _____

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: _____