

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 have (or have you had) any of the following medical conditions?

- | | |
|---|--|
| <input type="checkbox"/> No medical condition <input type="checkbox"/> | <input type="checkbox"/> Psoriasis |
| <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"/> Immunodeficiency disorder (i.e.: cancer treatment, HIV infection, high doses of steroids, graft) | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Coagulation disorder |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Anxiety | |

Do you take any medication?

- | | |
|---|---|
| <input type="checkbox"/> No medication | <input type="checkbox"/> I do not have the name, but I take medication for the following condition or of this type: _____ |
| <input type="checkbox"/> I take the following medication: | _____ |
| <input type="checkbox"/> Contraceptive: _____ | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> List: _____ | <input type="checkbox"/> Depression |
| _____ | <input type="checkbox"/> Anticoagulant / Warfarin / Coumadin |
| _____ | <input type="checkbox"/> Chemotherapy |
| _____ | <input type="checkbox"/> "Cortisone" |
| _____ | <input type="checkbox"/> Organ transplant, anti-reject |
| _____ | <input type="checkbox"/> Anti-viral medication (HIV, other) |

Do you have allergies?

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

Do you currently have a fever or an active infection? Yes No

WOMEN ONLY	Do you have any concern(s) regarding your period while on this trip? Yes <input type="checkbox"/> No <input type="checkbox"/>
Are you pregnant?	
Yes <input type="checkbox"/> - # of weeks: _____	
No <input type="checkbox"/> - Are you planning to become pregnant within 3 months? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Are you breastfeeding? Yes <input type="checkbox"/> No <input type="checkbox"/>	

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

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"/> Other: _____ |
| <input type="checkbox"/> Adoption | <input type="checkbox"/> Religious visit | |

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

I have not had any vaccinations in the past 10 years

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.

By the present document, I herein authorize Medisys, Medisys Travel Health Clinic and their medical and para-medical staff to proceed with the immunizations required for:

- the update of my immunizations
- the prevention of infections representing a risk for my health and/or
- my eventual trip abroad.

I have been advised of the potential risks associated with these immunizations, have received answers to my questions and have received instructions to follow in the event of vaccination side effects.

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.