

**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?**

Chronic or significant medical condition (specify)

i \_\_\_\_\_ ii \_\_\_\_\_

iii \_\_\_\_\_ iv \_\_\_\_\_

Seizures or convulsions

Immunosuppression/impaired immune system

Heart disease

Depression

Anxiety

Psoriasis

Thymus disease

Inflammatory bowel disease

Diabetes

Respiratory (lung) conditions

Liver disease

Coagulation disorder

Other: \_\_\_\_\_

**Are you taking any of the following medications?**

Anticonvulsants

Antidepressants

Anticoagulant / Warfarin / Coumadin

Chemotherapy

Steroids (prednisone)

Immunosuppressive drugs

Anti-viral medication (HIV, other)

Other: \_\_\_\_\_

**Are you allergic to any of the following?**

Eggs (describe reaction): \_\_\_\_\_

Food (describe reaction): \_\_\_\_\_

Wasp/Insect bites

Latex

Thimerosal or Aluminum

Neomycin

Sulfa, Sulfamycin, Bactrim, Septra

Penicillin

Tetracyclines

Formaldehyde or Phenol

Other: \_\_\_\_\_

**WOMEN 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

	Countries to be visited	Duration in urban areas	Duration in rural areas
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"/> 1st 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"/> D'T (Diphtheria/ Tetanus)	_____	<input type="checkbox"/> Polio	_____
<input type="checkbox"/> D'TaP (Adacel)	_____	<input type="checkbox"/> Pneumococcal	_____
<input type="checkbox"/> D'TP (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.