CAROLINA EXPRESS CLINIC

## Travel Consultation

Patient Name: _____

Date of Birth: ____/____/_____ Age_____ Gender: M ___ F ___ Phone # (_____)_____-_____

Place of travel: City _____ ____ Country _____Dates of travel: _____to _____

1. (Females only) Are you or will you become pregnant in the next 30 days? Yes No
2. (Females only) are you lactating? Yes No
3. Allergic to any of the following: **Neomycin, gelatin, polymixin, latex, thimerosal, albumin or eggs?** Yes No
4. Please list **current medications** (you may provide a list) _____ _____
5. Please list all **allergies including foods and medications**_____
6. Have you had an allergic reaction to a vaccine?_____ _____ Yes No
7. Do you have a history of Guillain-Barre Syndrome (GBS) or other neurological problems? Yes No
8. Have you received any additional vaccines in the last 30 days? List_____ Yes No
9. Have you received or has it been recommended that you receive medication to prevent Malaria? Yes No
10. Have you completed the vaccination series (2) for Hepatitis A vaccine? Yes No
11. Have you completed the vaccination series (2) for MMR i(Measles, Mumps, Rubella )? Yes No
12. Have you completed the vaccination series (4) for Polio? Yes No
13. Are you moderately ill or do you have a fever today? Yes No
14. Do you have any know liver or kidney disease? Yes No
15. Are you taking Coumadin? Yes No
16. Approximate Date of your last Typhoid vaccine if applicable?_____
17. Approximate Date of your last Meningitis vaccine if applicable?_____
18. Approximate Date of your last Tetanus or Tdap/Whooping Cough vaccine?_____

19. Vaccines/Medication Requested (please circle): **Tdap (Tetanus)** **Typhoid** **Hepatitis A**

**Hepatitis B** **Malaria Prophylaxis** **Anti-Diarrhea Med** **Japanese Encephalitis** **Polio**

**Meningitis** **MMR (Measles,Mumps,Rubella)** **Yellow Fever** **Flu** (Continued)

**The questions in this box pertain only to patients requesting YELLOW FEVER VACCINE**

1. Are you immunosuppressed or do you have any of the below?

HIV infection, leukemia, lymphoma, thymic disease, malignancy, myasthenia gravis, on immunosuppressive drugs, chemotherapy or radiation?

**Yes____ No ____**

2. Have you had any of the below in the last 3 months?

Steroids, Dimethyl Fumarate(TECFIDERA), Methotrexate, Azathioprine, Mercaptopurine (6-MP), Leflunomide(Arava), Tumor Necrosis Factor Inhibitor

**Yes____ No ____**

3. Is the patient over the age of 60 years (or) under the age of 9 months?

**Yes ____ No ____**

**Yes No** **Consent and Waiver** I hereby affirm that all of the information I have provided is true and correct. I understand the benefits and risks of vaccinations and that there may be additional unknown risks and I hereby consent to the administration of the vaccine(s) to myself or to the minor named above for whom I attest. I agree to make any inquiries regarding the vaccine(s) before the vaccine(s) is/are administered. In the event of an anaphylactic reaction, I authorize clinician to administer diphenhydramine or epinephrine in appropriate weight-based dosing to treat reaction symptoms. I have had the opportunity to read Carolina Express Clinic's Notice of Privacy Practices to my satisfaction prior to consent.

**Yes No** I understand that I am responsible for payment of amounts not covered by my medical insurance plan, including co-payments and deductibles

**Yes No** I have been offered a copy of the of vaccine information sheet and had an opportunity to read over all information. I understand the benefits vs risk of receiving the vaccine(s)

**YOUR SIGNATURE BELOW CONFIRMS YOUR CONSENT AND UNDERSTANDING OF THE ABOVE INFORMATION**

Signature of Participant/Guardian X_____Date ____/____/_____

If you are the Parent/Guardian print your name _____Relationship to patient (PARENT/GUARDIAN)