CAROLINA EXPRESS CLINIC ***TRAVEL CONSULTATION***

Patient Name: _____**Date of Birth:** ____/____/_____ **Age**_____ **Total Days of Travel**_____

Place of travel: City _____ ____ **Country** _____**Dates of travel:** _____to _____

Purpose of travel: Business/Vacation/Volunteer/Other **Accommodations**: Hotel/Family or Friends/Camping or Outdoor living

	Yes	No	Unsure
1. (Females only) Are you or will you become pregnant in the next 30 days?			
1. (Females only) are you lactating?			
2. Allergic to any of the following: **Neomycin, gelatin, polymyxin, latex, thimerosal, albumin or eggs?**			
6. Do you have a history of Guillain-Barre Syndrome (GBS) or other neurological problems?			
8. Have you received medication to prevent Malaria?			
9. Have you completed the vaccination series (2) for Hepatitis A vaccine?			
10. Have you completed the vaccination series (2) for MMR i(Measles, Mumps, Rubella)?			
11. Have you completed the vaccination series (4) for Polio?			
12. Are you moderately ill or do you have a fever today?			
13. Do you have any know liver or kidney disease?			
14. Are you taking Coumadin?			
15. Currently taking a Biologic/Tumor Necrosis Factor inhibitor or significantly immunocompromised?			

3. Please list **current medications** (you may provide a list) _____ _____
4. Please list all **allergies including foods and medications**_____
5. Have you had an allergic reaction to a vaccine? _____ _____
7. Have you received any additional vaccines in the last 30 days? List_____
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? _____

(continued)

19. Request (please circle): **Tdap (Tetanus)** **Typhoid (shot)**** **Hepatitis A** **Hepatitis B**

Malaria Prophylaxis** **Anti-Diarrhea Med**** **Japanese Encephalitis**** **Polio** **Meningitis**

MMR **Yellow Fever**** **Flu** **Cholera**** **Pre-travel COVID Test** *(must schedule separately)*

travel consultation required

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? | **Yes** | **No** |

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

2.Have you had any of the below in the last 3 months? | **Yes** | **No** |

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

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. I understand that this consent is valid and remains in effect as long as I am a patient of Carolina Express Clinic. The consent will remain in full force until revoked in writing.

My signature on this form indicated that: I understand that although every effort will be made to keep all risks and side effects to a minimum; risks, side effects, and complications can be unpredictable both in nature and severity; I understand that "Physician Extenders" including Physician Assistants and/or Advance Practice Nurses will be involved in my treatment. I understand that Carolina Express Clinic evaluates many conditions and the assessment of my condition can be limited to the diagnostic test available. I will contact my primary health care provider for any other specific medical questions I have regarding my medical condition(s) and/or treatment(s). By signing below, I hereby voluntarily give my consent to treatment at Carolina Express Clinic.

| **Yes** | **No** |

Cost of services I understand that I will be responsible for payment of services in full at the time of my visit. I understand that **travel consultation services and vaccines will not be submitted to my insurance regardless of my insurance plan.** For a complete list of vaccines and cost of services please visit our website **www.CarolinaExpressClinic.com**

| **Yes** | **No** |

VIS Sheet I have been offered a copy of the **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)