

You must remain in the clinic for 20 minutes following any vaccination

PATIENT INFORMATION (to be completed by the traveller)

Vaccines, medications and other travel recommendations will be tailored to suit your needs based on your response

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 18yrs): _____ lbs kg

Emergency Contact: _____ Phone: _____

Relationship to you: _____

In what country were you born? _____

If not in Canada, at what age did you leave your country of birth? _____

MEDICAL INFORMATION (this information will not be shared with your employer)

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

- No medical condition**
- Seizures or convulsions Psoriasis Thymus disease inflammatory bowel disease
 Diabetes Depression Liver disease Respiratory (lung) disease
 Anxiety Heart disease Coagulation disorder
 Immunodeficiency disorder (i.e.: cancer treatment, HIV infection, high doses of steroids, graft)
 Chronic or significant medical condition (specify) 1. _____
 2. _____ 3. _____
 Other: _____

Do you take any medication?

- No medication**
- I take the following medication:
- List: 1. _____ 2. _____
 3. _____ 4. _____
- I take medication for:
- Epilepsy Depression Anticoagulant/Warfarin / Coumadin Chemotherapy
 "Cortisone" Organ transplant, anti-reject Anti-viral medication (HIV)
 Other _____

Do you have allergies?

- No allergies**
- I have allergies to: _____
- Eggs (describe reaction): _____
 Antibiotics:
 Neomycin Sulfa, Sulfamycin, Bactrim, Septra Penicillin Tetracyclines Formaldehyde or Phenol

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

WOMEN ONLY

Are you pregnant? Yes - # of weeks: _____ Are you breastfeeding? Yes No
 No- Are you planning to become pregnant within 3 months? Yes No

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.

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

Please list all countries and regions you will visit 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: _____

Where will you be staying? _____

Activities: 1. _____ 2. _____
 3. _____ 4. _____
 5. _____ 6. _____
 7. _____ 8. _____

IMMUNIZATION

I have not had any vaccinations in the past 10 years

Have you ever had an adverse reaction to a vaccine? Yes No

If yes, please specify: _____

DISCLAIMER

- I have been advised of the potential risks associated with these immunizations
- I have received answers to my questions and instructions in the event of side effect(s) to the vaccine(s)
- All of the information on this form is accurate to the best of my knowledge and I understand that any false information could negatively impact my health.

I understand that Dawson Travel & Immunization Clinic is a private clinic and the costs associated with my consultation, services and/ or vaccinations received along with all material required for vaccination(s) are my responsibility.

 Signature Date: ____/____/____(DD/MM/YYYY)

If you have travel insurance through your place of employment you may be eligible for a refund. Please check with your employer to see if you qualify for drug/health coverage.