

Travel Medicine Information Sheet

Name: _____ DOB: _____

Travel Plan

Type of Travel: Business Tourist Student Mission
 Will you have access to medical care if necessary? _____

Destination(s) of Travel (include dates of arrival & departure for each country): _____

Mode(s) of Travel: _____

Medical History

List any major medical issues past or present (ex: diabetes, asthma, high blood pressure, irregular heartbeat):

Past surgeries: _____

Current Medications with dosage: _____

Allergies: (check any of the following to which you are allergic)

NO allergies Eggs Thimerisol Sulfa Neomycin Streptomycin Bee stings
 Other: _____

Do you have any condition which has or could lower your immune system? _____

WOMEN ONLY: Are you or could you be pregnant? _____ Are you breast-feeding? _____

Vaccine History: (please check any of the vaccinations or diseases you have had, note dates if possible)

<u>Disease/Vaccine</u>	<u>Date</u>	<u>Disease/Vaccine</u>	<u>Date</u>
<input type="checkbox"/> Measels (rubeola)	_____	<input type="checkbox"/> Pneumococcal	_____
<input type="checkbox"/> Mumps	_____	<input type="checkbox"/> Yellow Fever	_____
<input type="checkbox"/> Rubella (German measles)	_____	<input type="checkbox"/> Typhoid (oral/shot?)	_____
<input type="checkbox"/> Varicella (chicken pox)	_____	<input type="checkbox"/> Cholera	_____
<input type="checkbox"/> Hepatitis A	_____	<input type="checkbox"/> Immunoglobulin	_____
<input type="checkbox"/> Hepatitis B	_____	<input type="checkbox"/> Meningococcus	_____
<input type="checkbox"/> Influenza	_____	<input type="checkbox"/> Rabies	_____

In the past (including any childhood doses) have you received at least 3 doses of:

Tetanus/diphtheria (Td)? _____ Last dose date: _____

Polio vaccine? _____ Last dose date: _____

Consent for Treatment

I authorize Industrial Medical Group to administer the following vaccine(s):

Varicella Hepatitis B Meningitis Polio Thyphoid Zostavax
 Hepatitis A MMR Pneumonia Tdap/Td Yellow fever Other

The nature and benefits, the risks of possible side effects of the proposed vaccines(s) have been explained to me and I have been advised of my right to refuse such vaccines and the possible consequences of such a decision. I am aware that the vaccine(s) may not have the desired objectives and that no warranty or guarantee has been made.

Signature: _____ Date: _____