NAME:				DATE:
IMMUNIZATION HISTORY				
Have you received any vaccinations in the last 4 weeks?			Yes ____ No ____	
Do you have a written record of your vaccinations?			Yes ____ No ____	
Have you had any serious reactions to any vaccines?			Yes ____ No ____	
Vaccines	Date(s) received	Never had	Not Sure	Had disease
Tetanus-Diphtheria Vaccine or Tdap				
Measles, Mumps, Rubella (2 doses)				
Polio, childhood series				
Polio, adult booster				
Chicken pox (Varicella)(2 doses)				
Meningitis (Menomune or Menactra)				
Pneumonia				
Influenza (flu)				
Hepatitis A (2 doses)				
Hepatitis B (3 doses)				
Typhoid (___ oral ___ injectable)				
Yellow Fever				
Japanese Encephalitis (2 doses)				
Rabies (3 doses)				
Other vaccines:				

MEDICAL HISTORY

Psychiatric problems	Yes ____ No ____	Seizures	Yes ____ No ____	Gastrointestinal problems	Yes ____ No ____
Irregular heartbeat	Yes ____ No ____	Heart disease or surgery	Yes ____ No ____	Respiratory problems	Yes ____ No ____
Psoriasis	Yes ____ No ____	Immunity problems	Yes ____ No ____	Positive TB test	Yes ____ No ____
Cortisone	Yes ____ No ____	Anti cancer drugs	Yes ____ No ____	Immune suppression drugs	Yes ____ No ____
Prednisone	Yes ____ No ____	Other steroids	Yes ____ No ____	High blood pressure	Yes ____ No ____

Other:

Please explain any "yes" answers:

Have you had any surgeries? Yes ____ No ____ What kind?

PLEASE LIST ALL YOUR CURRENT MEDICATIONS (Include prescriptions, over-the counter, supplements, eye drops, and contraceptives)

Name of medication	Condition or reason for use	Name of medication	Condition or reason for use
1		5	
2		6	
3		7	
4		8	

I understand that payment for services is expected at the time of service by cash, credit, or debit, unless there is a corporate contract. I understand that International Travel Care does not accept or file any insurance including Medicare. I give my permission to International Travel Care to release medical information to my physician at my direction. I give my consent for immunization administration and understand that I will receive written and/or verbal information about each vaccine/medication and possible side effects. I understand that it is recommended that I remain in the office for at least 15 minutes following immunizations. Vaccines/ medications may not be exchanged or returned. Unopened travel supplies may be exchanged or returned within 14 days.

Traveler / Parent / Guardian signature ____ Date __________________