



WESTPORT WESTON HEALTH DISTRICT

180 Bayberry Lane, Westport, CT 06880-2855
Telephone: (203) 227-9571 Telefax: (203) 221-7199

TRAVEL CLINIC WORKSHEET

Legal Name: _____ Date of Birth: _____ Departure: _____

Address: _____ Town: _____ ZIP _____ E-mail: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____ Male Female

Physician: _____

Address: _____ Town: _____ ZIP _____ Phone: (_____) _____

Itinerary In Order of Travel:

No.	City & Country	Length of Stay	Planned Activities
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

For more extensive travel, attach additional itinerary.

Medical History

- Are you pregnant? Yes No Nursing? Yes No
 - Have you ever had a reaction after receiving an immunization, including fainting or feeling dizzy? Yes No
 - Have you ever had a serious reaction to: *(For checked items, please specify)*
 - Food _____
 - Medication _____
 - Vaccines _____
 - Please list any medical conditions: _____
- List all medications taken in the past 90 days or being taken currently (includes over the counter):

 - List any past surgeries: _____

Disease/Immunization History

	Date	Comment		Date	Comment
<input type="checkbox"/> Hepatitis A	_____	_____	<input type="checkbox"/> Polio	_____	_____
<input type="checkbox"/> Hepatitis B	_____	_____	<input type="checkbox"/> Rabies	_____	_____
<input type="checkbox"/> Immune Globulin	_____	_____	<input type="checkbox"/> DTaP, Tdap, Td	_____	_____
<input type="checkbox"/> Japanese Encephalitis	_____	_____	<input type="checkbox"/> Typhoid (Injected)	_____	_____
<input type="checkbox"/> Measles (before 1957)	_____	_____	<input type="checkbox"/> Typhoid (Oral)	_____	_____
<input type="checkbox"/> MMR	_____	_____	<input type="checkbox"/> Varicella(chicken pox)	_____	_____
<input type="checkbox"/> Meningococcal	_____	_____	<input type="checkbox"/> Yellow Fever	_____	_____
<input type="checkbox"/> Pneumococcal	_____	_____	<input type="checkbox"/> Zostavax (shingles)	_____	_____

I acknowledge that the above information is correct and complete.

Signature: _____
Parent/Guardian Signature: _____

Date: _____
Date: _____

Travel Immunization Record

THIS PAGE FOR OFFICE USE ONLY

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Patient Name: _____ **Birthdate:** _____

Vaccine	Date Given <i>mm/dd/yy</i>	Dose, Route	Site Given	Vaccine Manufacturer	Vaccine Lot No.	Expiration Date	VIS Given	Initials
Cholera								
Hepatitis A/B								
Hepatitis A/B								
Hepatitis A/B								
Hepatitis A								
Hepatitis A								
Hepatitis B								
Hepatitis B								
Hepatitis B								
Influenza								
Japan. Encephalitis								
Japan. Encephalitis								
Meningitis B								
Meningitis B								
MMR								
MMR								
Menomune								
Menactra/Menveo								
Pneumococcal								
Polio								
Rabies								
Rabies								
Rabies								
PPD (Tubersol)								
Tetanus/Diphtheria								
Tdap								
Typhoid (Inactive)								
Typhoid (oral)								
Yellow Fever								
Zostavax								
Other:								

Rabies: See special form

Comments: _____

<p>Return Appointments:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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Practitioner Orders

Per Standing Orders

Per PCP Referral

INACTIVATED OR SUBUNIT/COMPONENT VACCINES

Vaccine	Initial Series	Booster	Precautions	Vaccine	Initial Series	Booster	Precautions
<input type="checkbox"/> Hep A	0, 6-12 mos	ND	<12 mos of age Alum,phenoxyethanol	<input type="checkbox"/> Menactra	9 mos – 55 yrs	ND	HX GBS
				<input type="checkbox"/> Menomune	≥2 yrs.	3-5 yrs.	
				<input type="checkbox"/> Menveo	2mos – 55 yrs.	ND	
				<input type="checkbox"/> Meningitis B	0, 1 mos or 0,1,6 mos	10yr - 25 yr.	pregnancy
<input type="checkbox"/> Hep A/B	0, 1, 6 mos	ND	Yeast allergy/>18yr Neomycin,Thimerosal	<input type="checkbox"/> PPSV	Single dose		>2yr
<input type="checkbox"/> Hep B	0,1,2,12 mos 0, 1, 6 mos	Antibodies <10 IU/ml	Yeast allergy, Thimerosal	<input type="checkbox"/> PVC13	2,4,6 mos >19 yr x1 dose	12-15mos.	Premature Infants (apnea)
				<input type="checkbox"/> Rabies	0,7,21,or 28 days	Check antibodies every 2 yrs. for high risk	IM deltoid neomycin.
<input type="checkbox"/> Influenza	Single dose	1 yr	Severe egg allergy	<input type="checkbox"/> Tdap	Single dose <small>Can be admin. Regardless of interval since last Td.</small>	Each Pregnancy	>11yrs. Formaldehyde, phenoxy
<input type="checkbox"/> IPV	2,4,6-18 mos. +4-6 yrs.	10 yrs.	Neomy,Streptomycin Polymyxin B	<input type="checkbox"/> Td	Single dose	10 yrs.	>7 yrs. of age Thimerosal
<input type="checkbox"/> JE – IXIARO	0,28 days	>1 yr. (if at risk of exposure)	<2 mos/preg.	<input type="checkbox"/> Typhoid	Single dose	2 yrs.	Pregnancy/>2yrs Phenol.
				<input type="checkbox"/> DTap	2,4,6 mos.	15-18 mos	<7yrs.Neuro- logical conditions

ND: Not Determined

LIVE VACCINES

(Give same day or 1 month apart)

Vaccine	Initial Series	Booster	Precautions	Vaccine	Initial Series	Booster	Precautions
<input type="checkbox"/> Cholera	1 Packet (100ml Reconstituted)	ND	18yr-64yrs. Avoid food & drink 1 hr.before&1 hr. after ingestion.	<input type="checkbox"/> Oral Typhoid	Every other day x4	5 yrs	Preg/HIV/>6 yrs of age. Stomach disorder. Delay 24 hrs. after antibiotics or Mefloquine . Gelatin, yeast.
<input type="checkbox"/> Yellow Fever	single dose	Lifetime	Preg/HIV/Egg/gelatin, Thymus disorder <9 mos of age/>60 yr.	<input type="checkbox"/> Varicella	12-15 mos.	4-6 yrs	Gelatin/Neomy/HIV, Active TB,preg. Immune suppression
<input type="checkbox"/> MMR	12-15mos. 4-6 years.	ND	Preg/Neomy HIV/breast feeding, gelatin.	<input type="checkbox"/> Zostavax	Single dose	ND	Gelatin / ≥60 yrs. Consider separating shingles/pneumonia by 4 wks.
<input type="checkbox"/> PPD	Date: _____	Result :	_____				

PROPHYLAXIS: Specific type Instructions given: Yes No

- Diarrhea: Cipro 500 mg BID #2 as directed for diarrhea/dysentery
- Malaria: Chloroquine Phosphate (1)*
 Doxycycline (2)
 Malarone (3)
 Adult Rx: Atovaquone 250 mg; Proquanil 100 mg.
 Pediatric Rx: Atovaquone 62.5 mg; Proquanil 25 mg.
 Diamox as directed for high altitude.(4)
 Rifaximin(5)
 Azithromycin (6)

*May exacerbate psoriasis

- (1) Adult Dose: 500mg weekly start 1 wk before and continue 4 wks after. (Pedi dose 8.3 mg/Kg) travel.
- (2) Adult Dose: 100 mg daily, start day of departure, continue 4 wks after travel.
- (3) Adult Dose: (1) dose daily, starting 1-2 days before exposure and continuing for one week after travel. Pedi Dose as directed.
- (4) 125mg po BID start evening before reaching 12,000 ft.
- (5) 200 TID x 3 days >12 yrs.
- (6) As directed for T.D.

Signature:

NURSE:

PHYSICIAN:

DATE

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HIPAA PRIVACY NOTICE

The Westport Weston Health District has provided me with notice of its HIPAA Privacy Rule that describes how health information about me may be used or disclosed by its Department of Community Health, and how I can obtain access to this information. I have read the notice and have been offered a copy.

Signature: _____

Date: _____

INSURANCE

Please read and sign below acknowledging that you have been informed that your insurance provider may not cover vaccines given for travel. Payment is your responsibility. If you have questions, please contact your insurance company.

Signature: _____

Date: _____

INFORMED CONSENT FOR VACCINATION (IMMUNIZATION)

Vaccines play an important role in the prevention of serious illnesses. Although modern day vaccines have been refined and improved, adverse effects or reactions are possible.

Local side effects may include redness, tenderness or warmth at the injection site. Generalized, systemic reactions occur less frequently but may include fever, body aches, headache or malaise. Call if you are concerned about any reactions.

Live virus vaccines (e.g., oral typhoid, measles, mumps, rubella and yellow fever) produce a mild infection that provides immunity for a prolonged period of time.

If you are pregnant, live vaccines are not recommended unless you must travel to high risk areas. Do not become pregnant for three (3) months after receiving the MMR, yellow fever or chickenpox vaccines.

I have read the above information. I have had the opportunity to ask questions and agree to the administration of the indicated vaccines.

Signature: _____

Date: _____

Signature: _____

Date: _____

Signature: _____

Date: _____