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

1. Are you pregnant? ☐ **Yes** ☐ **No** **Nursing?** ☐ **Yes** ☐ **No**

2. Have you ever had a reaction after receiving an immunization, including fainting or feeling dizzy? ☐ **Yes** ☐ **No**

3. Have you ever had a severe allergic reaction to:

(For checked items, please specify)

- ☐ **Food** _____
- ☐ **Medication** _____
- ☐ **Vaccines** _____
- ☐ **Latex**_____

4. Please list any medical conditions:_____

_____

5. List all medications taken in the past 90 days or being taken currently (includes over the counter):

_____

_____

_____

6. List any past surgeries: _____

_____

_____

Disease/Immunization History

	Date	Comment		Date	Comment
☐ Hepatitis A			☐ Polio		
☐ Hepatitis B			☐ Rabies		
☐ Immune Globulin			☐ DTaP, Tdap, Td		
☐ Japanese Encephalitis			☐ Typhoid (Injected)		
☐ Measles (before 1957)			☐ Typhoid (Oral)		
☐ MMR			☐ Varicella(chicken pox)		
☐ Meningococcal			☐ Yellow Fever		
☐ Pneumococcal			☐ Shingles		

I acknowledge that the above information is correct and complete.

Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____

Travel Immunization Record

THIS PAGE FOR OFFICE USE ONLY

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Patient Name: _____ **Birthdate:** _____

Vaccine	Date Given *mm/dd/yy*	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								
Menactra/Menveo								
Pneumococcal								
Polio								
Rabies								
Rabies								
Rabies								
ShingRix								
PPD (Tubersol)								
Tetanus/Diphtheria								
Tdap								
Typhoid (Inactive)								
Typhoid (oral)								
Yellow Fever								
Other:								

Rabies: *See special form*

Comments: _____

_____

_____

_____

_____

Return Appointments:

_____

_____

_____

_____

☐**Practitioner Orders** ☐**Per Standing Orders** ☐ **Per PCP Referral**

INACTIVATED OR SUBUNIT/COMPONENT VACCINES

Vaccine	Initial Series	Booster	Precautions
☐ Hep A	0, 6-12 mos	ND	<12 mos of age Alum,phenoxyethanol
☐ Hep A/B	0, 1, 6 mos	ND	Yeast allergy/>18yr Neomycin,Thimerosal
☐ Hep B	0,1,2,12 mos 0, 1, 6 mos	Antibodies <10 IU/ml	Yeast allergy, Thimerosal
☐ Influenza	Single dose	1 yr	Severe egg allergy
☐ IPV	2,4,6-18 mos. +4-6 yrs.	10 yrs.	Neomy,Streptomycin Polymyxin B
☐ JE – IXIARO	0,28 days	>1 yr. (if at risk of exposure)	<2 mos/preg.

Vaccine	Initial Series	Booster	Precautions
☐ Menactra	9 mos – 55 yrs	ND	HX GBS
☐ Menveo	2 mos-55 Yrs.	ND	
☐ Meningitis B	0, 1 mos or 0,1,6 mos	10yr - 25 yr.	pregnancy
☐ PPSV	Single dose		>2yr
☐ PVC13	2,4,6 mos >19 yr x1 dose	12-15mos.	Premature Infants (apnea)
☐ Rabies	0,7,21,or 28 days	Check antibodies every 2 yrs. for high risk	IM deltoid neomycin.
☐ ShingRix	Single dose ND	/ ≥50 yrs. Consider separating shingles/pneumonia by 4 wks.	
☐ Tdap	Single dose Can be admin. Regardless of interval since last Td.	Each Pregnancy	>11yrs. Formaldehyde, phenoxy
☐ Td	Single dose	10 yrs.	>7 yrs. of age Thimerosal
☐ Typhoid	Single dose	2 yrs.	Pregnancy/>2yrs Phenol.
☐ 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
☐ Cholera	1 Packet (100ml Reconstituted)	ND	18yr-64yrs. Avoid food & drink 1 hr.before&1 hr. after ingestion.
☐ Yellow Fever	single dose	Lifetime	Preg / HIV / Egg/gelatin, Thymus disorder <9 mos of age/>60 yr.
☐ MMR	12-15mos. 4-6 years.	ND	Preg/Neomy HIV/breast feeding, gelatin.
☐ PPD Date: ———	Result: ———		

Vaccine	Initial Series	Booster	Precautions
☐ 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.
☐ Varicella	12-15 mos.	4-6 yrs	Gelatin/Neomy/HIV, Active TB,preg. Immune suppression

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: _____