**Travel Clinic Worksheet**
**Westport Weston Health District**
**180 Bayberry Lane Westport, CT 06880**
**Phone: (203) 227-9571 ▪ Fax: (203) 221-7199**

Legal Name: _____ DOB: _____ Mobile Phone: _____

Home Phone: _____ E-Mail: _____ Gender: _____

Address: _____ Town: _____ Zip: _____

Itinerary in order of travel: (for extensive travel please attach additional itinerary)

| Country & City | Length of stay | Planned Activities |
|---|---|---|
| | | |
| | | |

Please Circle your response(s) below:

1. Medical History: Are you pregnant? Yes No
2. Are you breast feeding/nursing? Yes No
3. Have you ever had a reaction to immunizations, including fainting or dizziness? Yes No
4. Do you have any food, medication, or environmental allergies? Yes No

If yes, please list all allergies with type of reaction:

| Allergy | Reaction |
|---|---|
| | |
| | |

Medical/Surgical History: (Please list all medical and surgical history):

_____

_____

Medications/over the counter meds (Please list everything you are on and have taken within the past 90 days):

| Medication name | Dose, frequency, and route taken |
|---|---|
| | |
| | |
| | |

**1.** The Westport Weston Health District has provided me with notice of the office HIPPA Privacy policy, including information disclosures and how to obtain access to information. I have read the HIPPA policy and have been offered a copy.

**2.** I acknowledge that my insurance provider may not cover vaccines and my office visit and I am responsible for payment at the time of my visit. If I have questions I will contact my insurance provider/company.

**3.** Prior to receiving my vaccines I have read all the given information about immunizations, potential side effects, risks, and had the opportunity to ask questions. If I am pregnant I am aware that I should not receive some vaccines unless I must travel to a high risk location. I understand I should not become pregnant three (3) months after receiving MMR, Yellow Fever, or chickenpox vaccines. I understand that live vaccines produce a mild infection that provides immunity. I am aware of potential risks in obtaining vaccines.

*I acknowledge that all the above information is correct and complete. I have read the above information and had the opportunity to ask questions. I am in agreement to the administration of indicated vaccines.

Name: _____ Signature: _____ Date: _____

Parent/Guardian Name:_____ Signature: _____ Date: _____