IDA Health and Travel
Riverdale, GA 30274

Patient Name:_____ Date of Birth: _____ Age: _____

Sex: _____Race: _____ Ethnicity: _____Mothers Maiden last name: _____

Address: _____City: _____State: _____Zip: _____

Telephone: _____ Do you Smoke: ☐Yes ☐No Packs per day _____ How Long? _____

Medical History:

Have you ever had a serious reaction after receiving a vaccination? ☐Yes ☐No
Do you have cancer, leukemia, AIDS, or any other immune system problem? ☐Yes ☐No
Do your take cortisone, prednisone, steroids, anticancer drugs or have you had x-ray treatments? ☐Yes ☐No
During the past year, have you received a transfusion of blood or blood products or been given a medication called immune (gamma) globulin? ☐Yes ☐No
Do you have any existing medical conditions such as diabetes, heart disease or pulmonary disease?
If so, please list:
_____

Women only: Are you pregnant, suspect you may be or are trying to become pregnant? ☐Yes ☐No

Ht: _____ Wt: _____ Allergies (Foods/Drugs)_____
_____
_____

List all medications you are taking:
_____
_____
_____

Immunization History:

Are you current with immunizations to date? ☐Yes ☐No
Have you had any Hepatitis Shots? ☐ Yes ☐No
When was your last Tetanus shot? _____
Have your received any vaccination in the past 4 weeks? ☐Yes ☐No

What is the name, address and phone number of your family physician?
_____
_____

Travel Information:

Date of Departure: _____Return Date: _____

Destination: _____ Length of Stay: _____

Destination: _____ Length of Stay: _____

How did you hear about our service: _____

The above information is true to the best of my knowledge and I authorize IDA to administer the recommended / required vaccinations of my choice.

Signature:_____ Date: _____

Vitals: _____ **B/P** _____ **Pulse** _____ **Temp** _____ **Resp**

Recommended Vaccines:

Hepatitis A	☐	Hepatitis B	☐	Td / Tdap	☐		
Yellow Fever	☐	Typhoid	☐	Polio	☐		
Pneumococcal	☐	Meningococcal	☐	Flu	☐		
Rabies	☐	JE	☐	Zoster	☐	MMR	☐

Declined vaccines: _____Yes _____ No Comment:_____

_____

_____

Vaccine	Lot #	Expiration Date	Site	Route

_____ Aralen 500 mg # _____, 1 tablet po starting one week pre-travel and continuing weekly thru stay and for 4 weeks post travel.

_____ Lariam 250mg # _____, 1 tablet po starting one week pre-travel and continuing weekly thru stay and for 4 weeks post travel.

_____ Malarone 250mg/100mg # _____, begin 1-2 days pre-travel, daily and continues for 7 days post travel.

_____ Malarone 62.5mg/25mg # _____, begin 1-2 days pre-travel, daily and continues for 7 days post travel.

_____ Other Rx provided: _____

_____

_____

Certification of Immunization provided ☐ Yes ☐ No

Comments: _____

_____

_____

Nurse Signature: _____ Date: _____