

CLIENT INTAKE FORM 1 - PLEASE FILL OUT SECTIONS A & C ONLY

SECTION A														
Last Name:			Middle Initial:		Date:									
First Name:			Sex: <input type="checkbox"/> M <input type="checkbox"/> F		Personal Health Number:									
Date of Birth:		Y			M			D		Age:	Email:		CDN Citizen: <input type="checkbox"/> Y <input type="checkbox"/> N	
Address:					City/Prov:			Postal Code:						
Name of Guardian:				Child's Weight:		Parental Consent (Signature):								
Your Tel #:		Emergency Contact (EC) Tel #:				Name of EC:								
ALLERGIES:					MEDICATIONS:									
Current Medical Conditions:														
Itinerary Destination (Country / Cities)			Length of Stay (Days / Weeks)			Type of Travel (Hotel, Backpacking, Work, Visit Family)								
Date of Departure:			I agree TravelSafe Clinic can email me a reminder for my booster vaccine(s): <input type="checkbox"/> Y <input type="checkbox"/> N											

SECTION B		SECTION C	
Immunization History	Last Dose	Medical History	Yes / No
1. Tetanus / Diphtheria		1. Fever in last 24 hours?	<input type="checkbox"/> Y <input type="checkbox"/> N
2. Measles, Mumps & Rubella		2. Fainted or felt dizzy from an injection?	<input type="checkbox"/> Y <input type="checkbox"/> N
3. Polio		3. Immune suppression (i.e. HIV, cancer)? Taking immune suppression medication?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N
4. Varicella (Chicken Pox)		4. G6PD deficiency?	<input type="checkbox"/> Y <input type="checkbox"/> N
5. Pertussis (Whooping Cough)		5. History of anxiety or depression?	<input type="checkbox"/> Y <input type="checkbox"/> N
6. Hepatitis A		6. Digestive disorders (IBS, Colitis, Crohn's)?	<input type="checkbox"/> Y <input type="checkbox"/> N
7. Hepatitis A / Typhoid (Vivaxim)		7. Pregnant or planning pregnancy?	<input type="checkbox"/> Y <input type="checkbox"/> N
8. Hepatitis B		8. Heart disease?	<input type="checkbox"/> Y <input type="checkbox"/> N
9. Hepatitis A / B (Twinrix)		9. Diabetes?	<input type="checkbox"/> Y <input type="checkbox"/> N
10. Typhoid <input type="checkbox"/> PO <input type="checkbox"/> INJ		10. Disorder of liver, spleen or kidney?	<input type="checkbox"/> Y <input type="checkbox"/> N
11. <input type="checkbox"/> ACYW-135 <input type="checkbox"/> MenC		11. Recent blood transfusion or blood products?	<input type="checkbox"/> Y <input type="checkbox"/> N
12. Yellow fever		12. Thymus disorder?	<input type="checkbox"/> Y <input type="checkbox"/> N
13. Japanese encephalitis		13. Seizures, epilepsy?	<input type="checkbox"/> Y <input type="checkbox"/> N
14. Rabies		14. History of Guillain-Barre Syndrome?	<input type="checkbox"/> Y <input type="checkbox"/> N
15. Dukoral		15. Bleeding disorder?	<input type="checkbox"/> Y <input type="checkbox"/> N
16. Influenza		16. Other?	<input type="checkbox"/> Y <input type="checkbox"/> N
17. <input type="checkbox"/> Pneumo23 <input type="checkbox"/> Prevnar13		HEALTH HISTORY NOTES (For Medical Staff Only):	
18. HPV (Gardasil 9)			
19. <input type="checkbox"/> Zostavax <input type="checkbox"/> Shingrix			
20. Other			

Consultant's Initials:	
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Client's Name:			Date Stamp 1:		
Consultant Discussed		Recommended Vaccine	Dose	Lot #	Price \$
Food and water safety	<input type="checkbox"/>	<input type="checkbox"/> Td <input type="checkbox"/> TdP <input type="checkbox"/> TdaP	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> B		\$
Insect bites and precautions	<input type="checkbox"/>	Polio	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> B		\$
Hepatitis A	<input type="checkbox"/>	MMR	<input type="checkbox"/> 1 <input type="checkbox"/> 2		\$
Typhoid	<input type="checkbox"/>	Varicella	<input type="checkbox"/> 1 <input type="checkbox"/> 2		\$
Rabies	<input type="checkbox"/>	Hepatitis A	<input type="checkbox"/> 1 <input type="checkbox"/> 2		\$
Meningitis	<input type="checkbox"/>	Hepatitis B	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		\$
Yellow fever	<input type="checkbox"/>	Hepatitis A / B (Twinrix)	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		\$
Japanese encephalitis	<input type="checkbox"/>	Hepatitis A / Typhoid (Vivaxim)	<input type="checkbox"/> 1 <input type="checkbox"/> 2		\$
Malaria	<input type="checkbox"/>	Rabies	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		\$
STD prevention	<input type="checkbox"/>	Yellow fever	<input type="checkbox"/> 1 <input type="checkbox"/> B		\$
Dengue/Chick/Zika	<input type="checkbox"/>	Japanese encephalitis	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> B		\$
Altitude sickness	<input type="checkbox"/>	Meningitis (ACYW-135)	<input type="checkbox"/> 1		\$
Hepatitis B/C & HIV	<input type="checkbox"/>	Typhoid <input type="checkbox"/> PO <input type="checkbox"/> INJ	<input type="checkbox"/>		\$
MVA	<input type="checkbox"/>	Dukoral	<input type="checkbox"/> 1 <input type="checkbox"/> B		\$
Travel insurance	<input type="checkbox"/>	Influenza	<input type="checkbox"/>		\$
<input type="checkbox"/> Sun Safety <input type="checkbox"/> Jet Lag <input type="checkbox"/> Medical Kit <input type="checkbox"/> Info Booklet Given		Pneumococcal 23	<input type="checkbox"/> 1		\$
Prescriptions		# Tablets	Pneumococcal / Prevnar 13	<input type="checkbox"/> 1	\$
Malarone	<input type="checkbox"/> Declined		<input type="checkbox"/> Zostavax <input type="checkbox"/> Shingrix	<input type="checkbox"/> 1 <input type="checkbox"/> 2	\$
Doxycycline	<input type="checkbox"/> Declined		HPV (Gardasil 9)	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	\$
Mefloquine	<input type="checkbox"/> Declined		Other		\$
Chloroquine	<input type="checkbox"/> Declined		Consult Fee		\$
Cipro	<input type="checkbox"/> Declined	<input type="checkbox"/> 6 <input type="checkbox"/> 12	Tubersol TB skin test	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Azithro	<input type="checkbox"/> Declined	<input type="checkbox"/> 6 <input type="checkbox"/> 12	→ Time of skin test:		
Diamox	<input type="checkbox"/> Declined		→ Result (48-72 hrs later) <input type="checkbox"/> Neg <input type="checkbox"/> Pos	If Positive: <input type="checkbox"/> Swelling <input type="checkbox"/> Redness / Induration. Measurement in mm:	
Immunizer's Initials:			→ Follow-up Required? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes: <input type="checkbox"/> Sent for chest x-ray	
				TOTAL \$	\$

Lab Work:	<input type="checkbox"/> HepBsAb <input type="checkbox"/> HepBsAg <input type="checkbox"/> Varicella <input type="checkbox"/> MMR <input type="checkbox"/> Rabies <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Requisition Given
Routine Schedule:	<input type="checkbox"/> 0, 1, 6 months Hepatitis B Twinrix <input type="checkbox"/> 0, 6 months Hepatitis A <input type="checkbox"/> 0, 0, 6 months Hepatitis B Twinrix
	<input type="checkbox"/> 0, 2, 6 months Gardasil 9 <input type="checkbox"/> 0, 2-6 months Shingrix <input type="checkbox"/> 0, 7, 21-28 days Rabies <input type="checkbox"/> 0, 7 days Japanese Enc <input type="checkbox"/> 0, 28 days Japanese Enc <input type="checkbox"/> 12-24 months
Rapid Schedule:	<input type="checkbox"/> 0, 7, 21 days, 1 year Hepatitis B Twinrix <input type="checkbox"/> 0, 4+ weeks MMR <input type="checkbox"/> 0, 6 weeks Varicella

Date Stamp 2				Date Stamp 3			
Vaccine	Dose	Lot #	Price \$	Vaccine	Dose	Lot #	Price \$
<input type="checkbox"/> Td <input type="checkbox"/> TdP <input type="checkbox"/> TdaP	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> B		\$	<input type="checkbox"/> Td <input type="checkbox"/> TdP <input type="checkbox"/> TdaP	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> B		\$
Polio	<input type="checkbox"/> B		\$	Polio	<input type="checkbox"/> B		\$
MMR	<input type="checkbox"/> 1 <input type="checkbox"/> 2		\$	MMR	<input type="checkbox"/> 1 <input type="checkbox"/> 2		\$
Varicella	<input type="checkbox"/> 1 <input type="checkbox"/> 2		\$	Varicella	<input type="checkbox"/> 1 <input type="checkbox"/> 2		\$
Hepatitis A	<input type="checkbox"/> 1 <input type="checkbox"/> 2		\$	Hepatitis A	<input type="checkbox"/> 1 <input type="checkbox"/> 2		\$
Hepatitis B	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		\$	Hepatitis B	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		\$
Hepatitis A/B (Twinrix)	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		\$	Hepatitis A/B (Twinrix)	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		\$
Hepatitis A/Typhoid (Vivaxim)	<input type="checkbox"/> 1 <input type="checkbox"/> 2		\$	Hepatitis A/Typhoid (Vivaxim)	<input type="checkbox"/> 1 <input type="checkbox"/> 2		\$
Rabies	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		\$	Rabies	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		\$
Yellow fever	<input type="checkbox"/> 1 <input type="checkbox"/> B		\$	Yellow fever	<input type="checkbox"/> 1 <input type="checkbox"/> B		\$
Japanese encephalitis	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> B		\$	Japanese encephalitis	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> B		\$
Meningitis (ACYW-135)	<input type="checkbox"/>		\$	Meningitis (ACYW-135)	<input type="checkbox"/>		\$
Typhoid <input type="checkbox"/> PO <input type="checkbox"/> INJ	<input type="checkbox"/>		\$	Typhoid <input type="checkbox"/> PO <input type="checkbox"/> INJ	<input type="checkbox"/>		\$
Dukoral	<input type="checkbox"/> 1 <input type="checkbox"/> B		\$	Dukoral	<input type="checkbox"/> 1 <input type="checkbox"/> B		\$
Influenza	<input type="checkbox"/>		\$	Influenza	<input type="checkbox"/>		\$
Pneumococcal 23	<input type="checkbox"/> 1		\$	Pneumococcal 23	<input type="checkbox"/> 1		\$
Pneumococcal / Prevnar 13	<input type="checkbox"/> 1		\$	Pneumococcal / Prevnar 13	<input type="checkbox"/> 1		\$
<input type="checkbox"/> Zostavax <input type="checkbox"/> Shingrix	<input type="checkbox"/> 1 <input type="checkbox"/> 2		\$	<input type="checkbox"/> Zostavax <input type="checkbox"/> Shingrix	<input type="checkbox"/> 1 <input type="checkbox"/> 2		\$
HPV (Gardasil 9)	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		\$	HPV (Gardasil 9)	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		\$
Other			\$	Other			\$
Immunizer's Initials:		TOTAL \$	\$	Immunizer's Initials:		TOTAL \$	\$

Date Stamp 4							
Vaccine	Dose	Lot #	Price \$	Vaccine	Dose	Lot #	Price \$
<input type="checkbox"/> Twinrix <input type="checkbox"/> Hepatitis B	<input type="checkbox"/> 3 <input type="checkbox"/> 4		\$	Rabies	<input type="checkbox"/> 3		\$
JE/Ixiaro	<input type="checkbox"/> 2 <input type="checkbox"/> 3		\$	Other			\$
Immunizer's Initials:		TOTAL \$	\$	Immunizer's Initials:		TOTAL \$	\$

CLINIC NOTES: