

**CLIENT INTAKE FORM 2 - 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:	
Address:				City/Prov:				Postal Code:			
Name of Guardian:				Child's Weight:		Parental Consent (Signature):					
Your Tel #:			Emergency Contact (EC) Tel #:				Name of EC:				
I agree TravelSafe Clinic can email me a reminder for my booster vaccine(s): <input type="checkbox"/> Y <input type="checkbox"/> N											
<b>PLEASE SELECT THE REASON FOR YOUR APPOINTMENT WITH TRAVELSAFE CLINIC:</b>											
<b>OCCUPATIONAL HEALTH:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO <b>If YES, what is the name of your school or employer?</b>											
<i>FOR STUDENTS ONLY</i>		I agree to allow TravelSafe Clinic to inform my school of my vaccine records: <input type="checkbox"/> Y <input type="checkbox"/> N									
<b>IMMIGRATION:</b> <input type="checkbox"/>						<b>HAJJ:</b> <input type="checkbox"/>					
<b>ALLERGIES:</b>						<b>MEDICATIONS:</b>					
<b>Current Medical Conditions:</b>											

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 checked="" 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		<b>HEALTH HISTORY NOTES (For Medical Staff Only):</b>	
18. HPV (Gardasil 9)			
19. <input type="checkbox"/> Zostavax <input type="checkbox"/> Shingrix			
20. Other			

<b>Consultant's Initials:</b>	
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<b>Client's Name:</b>							
<b>Date Stamp 1</b>				<b>Date Stamp 2</b>			
<b>Recommended Vaccine</b>	<b>Dose</b>	<b>Lot #</b>	<b>Price \$</b>	<b>Recommended Vaccine</b>	<b>Dose</b>	<b>Lot #</b>	<b>Price \$</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		\$	<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"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <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		\$
Meningitis (ACYW-135) / B	<input type="checkbox"/> 1		\$	Meningitis (ACYW-135) / B	<input type="checkbox"/>		\$
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		\$
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			\$
Consult Fee			\$				\$
<b>Immunizer's Initials:</b>		<b>TOTAL \$</b>	<b>\$</b>	<b>Immunizer's Initials:</b>		<b>TOTAL \$</b>	<b>\$</b>
<b>TB SECTION – TO BE COMPLETED BY MEDICAL STAFF ONLY</b>							
<b>History of BCG</b> <input type="checkbox"/> Yes <input type="checkbox"/> No						<b>History of Positive TST</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
If YES, 939 req given/faxed to TB Control <input type="checkbox"/>						Country of Origin:	
Date TST Administered:		Time:		RN Signature:			\$
Date TST Read:		Time:		RN Signature:			
➔ Result (48-72 hrs later) <input type="checkbox"/> Neg <input type="checkbox"/> Pos						If Positive: <input type="checkbox"/> Swelling <input type="checkbox"/> Redness / Induration <input type="checkbox"/> Other reaction (describe):	
➔ Follow-up: <input type="checkbox"/> No further follow-up <input type="checkbox"/> Repeat in 2 Weeks <input type="checkbox"/> Recommended chest x-ray <input type="checkbox"/> 939 requisition given						Measurement mm:	
<b>2 Step Date TST Administered:</b>				Time:		RN Signature:	\$
Date TST Read:				Time:		RN Signature:	
➔ Result (48-72 hrs later) <input type="checkbox"/> Neg <input type="checkbox"/> Pos						If Positive: <input type="checkbox"/> Swelling <input type="checkbox"/> Redness / Induration <input type="checkbox"/> Other reaction (describe):	
➔ Follow-up: <input type="checkbox"/> No further follow-up <input type="checkbox"/> Recommended chest x-ray <input type="checkbox"/> 939 requisition given						Measurement in mm:	
<b>CLINIC NOTES:</b>						<b>TOTAL \$</b>	<b>\$</b>
<b>Lab Work:</b> <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							
<b>Routine Schedule:</b> <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							
<b>Rapid Schedule:</b> <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							
<b>Date Stamp 3</b>							
<b>Vaccine</b>	<b>Dose</b>	<b>Lot #</b>	<b>Price \$</b>	<b>Vaccine</b>	<b>Dose</b>	<b>Lot #</b>	<b>Price \$</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		\$	Meningitis	<input type="checkbox"/>		\$
Polio	<input type="checkbox"/> B		\$	Japanese encephalitis	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> B		\$
MMR	<input type="checkbox"/> 1 <input type="checkbox"/> 2		\$	Typhoid <input type="checkbox"/> PO <input type="checkbox"/> INJ	<input type="checkbox"/>		\$
Varicella	<input type="checkbox"/> 1 <input type="checkbox"/> 2		\$	Dukoral	<input type="checkbox"/> 1 <input type="checkbox"/> B		\$
Hepatitis A	<input type="checkbox"/> 1 <input type="checkbox"/> 2		\$	Influenza	<input type="checkbox"/>		\$
Hepatitis B	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		\$	Pneumococcal 23	<input type="checkbox"/> 1		\$
Hepatitis A/B (Twinrix)	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		\$	Pneumococcal / Prevnar 13	<input type="checkbox"/> 1		\$
Hepatitis A/Typhoid (Vivaxim)	<input type="checkbox"/> 1 <input type="checkbox"/> 2		\$	<input type="checkbox"/> Zostavax <input type="checkbox"/> Shingrix	<input type="checkbox"/> 1 <input type="checkbox"/> 2		\$
Rabies	<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		\$
Yellow fever	<input type="checkbox"/> 1 <input type="checkbox"/> B		\$	Other			\$
<b>Immunizer's Initials:</b>		<b>TOTAL \$</b>	<b>\$</b>	<b>Immunizer's Initials:</b>		<b>TOTAL \$</b>	<b>\$</b>
<b>Date Stamp 4</b>							
<b>Vaccine</b>	<b>Dose</b>	<b>Lot #</b>	<b>Price \$</b>	<b>Vaccine</b>	<b>Dose</b>	<b>Lot #</b>	<b>Price \$</b>
<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			\$
<b>Immunizer's Initials:</b>		<b>TOTAL \$</b>	<b>\$</b>	<b>Immunizer's Initials:</b>		<b>TOTAL \$</b>	<b>\$</b>
<b>CLINIC NOTES:</b>							