DAWSON TRAVEL & IMMUNIZATION CLINIC

You must remain in the clinic for 20 minutes following any vaccination

PATIENT INFORMATION (to be completed by the traveller)

Vaccines, medications and other travel recommendations will be tailored to suit your needs based on your response

Gender: □ Male □ Female □ Other Date of birth: ___/___/_____(DD/MM/YYYY)
Last Name: _____ First Name:_____
Street: _____City: _____Province_____
Country: _____ Postal Code:_____
Phone (Home): _____ (Work): _____(Cell):_____
E-mail: _____ Weight (if under 18yrs): _____ □ lbs □ kg
Emergency Contact: _____ Phone: _____
Relationship to you:_____
In what country were you born?_____
If not in Canada, at what age did you leave your country of birth? _____

MEDICAL INFORMATION (this information will not be shared with your employer)

Do you have (or have you had) any of the following medical conditions?

☐ **No medical condition**

☐ Seizures or convulsions ☐ Psoriasis ☐ Thymus disease ☐ inflammatory bowel disease
☐ Diabetes ☐ Depression ☐ Liver disease ☐ Respiratory (lung) disease
☐ Anxiety ☐ Heart disease ☐ Coagulation disorder
☐ Immunodeficiency disorder (i.e.: cancer treatment, HIV infection, high doses of steroids, graft)
☐ Chronic or significant medical condition (specify) 1. _____
2._____ 3. _____
☐ Other: _____

Do you take any medication?

☐ **No medication**

I take the following medication:

☐ List: 1. _____ 2. _____
3. _____ 4. _____

I take medication for:

☐ Epilepsy ☐ Depression ☐ Anticoagulant/Warfarin / Coumadin ☐ Chemotherapy
☐ "Cortisone" ☐ Organ transplant, anti-reject ☐ Anti-viral medication (HIV)
☐ Other _____

Do you have allergies?

☐ **No allergies**

☐I have allergies to: _____
_____
☐ Eggs (describe reaction): _____
☐ Antibiotics:
☐ Neomycin ☐ Sulfa, Sulfamycin, Bactrim, Septra ☐ Penicillin ☐Tetracyclines ☐ Formaldehyde or Phenol

Do you currently have a fever or an active infection? ☐ Yes ☐ No

For whom it is applicable

Are you pregnant? ☐ Yes - # of weeks: _____ Are you breastfeeding? ☐ Yes ☐ No
☐ No- Are you planning to become pregnant within 3 months? ☐ Yes ☐ No

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Most vaccines are generally well tolerated; however, you may experience some soreness, redness and swelling at the injection site. Other adverse reactions may include headaches, fever, fatigue, and muscle pain. As with any vaccine, an allergic reaction or anaphylactic response could occur.

ITINERARY Departure date: _____/_____/_____(DD/MM/YYYY) Duration of trip:_____

Please list all countries and regions you will visit during your trip

	Countries to be visited	Urban areas/Duration	Rural areas/ Duration
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			

Purpose of trip: _____
_____

Where will you be staying? _____
_____

Activities: 1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____

IMMUNIZATION

☐ I have not had any vaccinations in the past 10 years

Have you ever had an adverse reaction to a vaccine? Yes ☐ No ☐

If yes, please specify: _____

DISCLAIMER

☐ I have been advised of the potential risks associated with these immunizations

☐ I have received answers to my questions and instructions in the event of side effect(s) to the vaccine(s)

☐ All of the information on this form is accurate to the best of my knowledge and I understand that any false information could negatively impact my health.

I understand that Dawson Travel & Immunization Clinic is a private clinic and the costs associated with my consultation, services and/ or vaccinations received along with all material required for vaccination(s) are my responsibility.

I hereby authorize to disclose all travel health consult information to my Family Physician: _____

_____ Date:_____/_____/_____(DD/MM/YYYY)
Signature

If you have travel insurance through your place of employment you may be eligible for a refund. Please check with your employer to see if you qualify for drug/health coverage.