

**ADULT INFO SHEET**

**INTERNATIONAL TRAVEL**

Name: Last		First	Middle Initial	Birth Date	Age
Mailing Address			City	County	State Zip
Phone	Race	Family Doctor	Employer/School		Sex: M F

1. Will you be returning to the Health Department for the next immunizations? . . . . . YES NO
2. Has this client had vaccines elsewhere in the past 6 months? . . . . . YES NO
3. Is this client ill, have any ongoing medical problems, or history of thrombocytopenia? . . . . . YES NO  
If YES, list them \_\_\_\_\_
4. Has this client taken any medications this past week? . . . . . YES NO
5. Has client had a reaction to latex, neomycin, streptomycin, eggs, yeast, gelatin or past immunizations? . . YES NO
6. Has this client had Immune Globulin or a blood transfusion in the last three months? . . . . . YES NO
7. Is anyone in this client's home taking medications for cancer or have any disease which reduces their immune function (Hodgkin's Disease, etc.)? . . . . . YES NO
8. Has this client, parents, or sibling ever had a convulsion, seizure, or history of Gullain-Barre Syndrome? . . YES  
NO
9. Are you pregnant, think you are pregnant, or might get pregnant in the next three months? . . . . . YES NO
10. Has this client ever had the chickenpox disease? . . . . . YES NO
11. This client: **(circle one)** 1) Has health insurance that does not cover immunizations  
2) Has health insurance that covers immunizations 3) Is covered by Medicaid 4) Does not have health insurance

I have received a copy of appropriate information about the disease(s) and vaccine(s) listed below. I have read or have had explained to me this information. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) and ask that the vaccine(s) indicated on this record be given to me or to the person above for whom I am authorized to make this request. **I have been advised to wait 15 minutes after the injection to monitor for signs and symptoms of an allergic reaction.** I give permission to the Sidney-Shelby County Health Department to release my immunization records to any doctor or agency when the immunization record is requested.

**For Medicare Part B Recipients:** I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment. I understand I will be billed directly for payment if the Health Department is not reimbursed from Medicare.

**Medicare Beneficiary Claim Number (HIC):** \_\_\_\_\_

Signature of person to receive vaccine or person authorized to make the request:  
**X** \_\_\_\_\_ **Date:** \_\_\_\_\_

\* \* \* \* \* **HEALTH DEPARTMENT STAFF USE ONLY** \* \* \* \* \*

**VIS DATES:** MMR: 01/03 HEP B: 7/07 PCV7: 12/08 Var: 12/98 TD: 6/94 Hep A: 3/06 Mening: 1/08 IPV 1/00 Pneu: 4/09  
 TYPHOID : 05/04 Yellow Fever: 11/04 HPV 5/11 Tdap 11/08 Shingles 9/06 Flu 8/31/11

Vaccine	Date Given	Manufacturer	Lot Number	Site	Route	Administered By
_____				LA RA LT RT	PO ID IM SQ	
_____				LA RA LT RT	PO ID IM SQ	
_____				LA RA LT RT	PO ID IM SQ	
_____				LA RA LT RT	PO ID IM SQ	

- HIPAA notice provided
- VIS provided
- Cash
- Check

TOTAL CHARGE: \$ \_\_\_\_\_ Initials \_\_\_\_\_ Receipt # \_\_\_\_\_ Medicaid # \_\_\_\_\_

Date: \_\_\_\_\_

Nurse Initials: \_\_\_\_\_

## Nursing Assessment – International Travel

Client Name: \_\_\_\_\_ Age: \_\_\_\_\_ Phone#: \_\_\_\_\_

Destination (countries and cities in order of itinerary)

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Date of travel: \_\_\_\_\_ Length of stay: \_\_\_\_\_

Nature of visit:  Adoption  Medical  Mission  Safari  Vacation  Work

Special Planned Activities (mountain climbing, driving, hunting, ect.)

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Special needs (handicapped, pregnant, chronic illness, ect.)

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Previous international travel: \_\_\_\_\_

Recommended vaccines:

- |                                |                                     |                                    |                                   |                                       |
|--------------------------------|-------------------------------------|------------------------------------|-----------------------------------|---------------------------------------|
| <input type="checkbox"/> Flu   | <input type="checkbox"/> HPV        | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Shingles | <input type="checkbox"/> Typhoid      |
| <input type="checkbox"/> Hep A | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Polio     | <input type="checkbox"/> Td/Tdap  | <input type="checkbox"/> Varicella    |
| <input type="checkbox"/> Hep B | <input type="checkbox"/> MMR        | <input type="checkbox"/> Rabies    | <input type="checkbox"/> Twinrix  | <input type="checkbox"/> Yellow Fever |

Malaria Recommendation:

- Cloroquine resistance
- Referred to Doctor

Protective measures reviewed (at clinic visit)

- Food/water precautions
- Diarrhea Medication
- Handwashing
- Insect protection
- Sun sensitivity/sunscreen use

Additional Comments: \_\_\_\_\_

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