CHILDREN INFO. SHEET **INTERNATIONAL TRAVEL**

Name: Last	First	Middle Initial	Birth Date	Age

Mailing Address	City	County	State	Zip

Telephone	Alternative Phone	Race **(circle one)** Asian Black Hispanic White American Indian Alaskan Native Multi-Race Other	Sex: M F

Date of Last Well Child Exam	Child's Doctor	School/Daycare

1. Will you be returning to the Health Department for the next immunizations? . . . . YES NO
2. If client is a child, do you have legal custody or written permission from parent/guardian for treatment? . YES NO
   If NO, talk to Health Department staff immediately.
3. Has this client had vaccines elsewhere in the past 6 months? . . . . YES NO
4. Is this client ill, have any ongoing medical problems, or history of thrombocytopenia? . . . . YES NO
   If YES, list them ______________________________
5. Has this client taken any medications this past week? . . . . YES NO
6. Has client had a reaction to latex, neomycin, streptomycin, eggs, yeast, gelatin or past immunizations?. . YES NO
7. Has this client had Immune Globulin or a blood transfusion in the last three months? . . . . YES NO
8. 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
9. Has this client, parents, or sibling ever had a convulsion, seizure, or history of Gullain-Barre Syndrome? . YES NO
10. Are you pregnant, think you are pregnant, or might get pregnant in the next three months? . . . . YES NO
11. Has this client ever had the chickenpox disease? . . . . YES NO
12. 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
13. This client would like referral to: **(please circle)** **1)** WIC **2)** Help Me Grow **3)** Well Child Clinic

I have received a copy of appropriate information about the disease(s) and vaccine(s) indicated 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 systems of an allergic reaction.***

I give permission to the Sidney-Shelby County Health Department to release/receive the immunization records of the above named child to any doctor, school and/or agency when the immunization record is requested. I also acknowledge receipt of the Shelby County Health Department's Notice of Health Information Privacy Practices.

Signature of person to receive vaccine or person authorized to make the request (parent or guardian):

X ______________________________ Date: ____________________

Relationship to Client:

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

VIS Dates: DTaP: 5/07 IPV: 1/00 Hib: 12/98 MMR 3/08 HEP B: 7/07 PCV7: 12/08 Var: 3/08 TDAP: 11/08 Hep A: 3/06 Mening: 1/08 RotaV 8/08 HPV 5/11 PPV4/09 TD 6/94 MULTI BABY 9/08 TYPHOID 5/04 YELLOW FEVER 3/11 FLU INACT 07/11

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	
				LA RA LT RT	PO ID IM SQ	

- ❑ HIPAA notice provided
- ❑ VIS provided
- ❑ Cash
- ❑ Check

TOTAL CHARGE: $ ____________ Initials ______ Receipt # _____________ Medicaid # ________________________

Sidney-Shelby County Health Department 202 W. Poplar St., Sidney, OH 45365 Phone: (937) 498-7249 Fax (937) 498-7013

Date:_________________________ Nurse Initials:_____

Nursing Assessment – International Travel

Client Name:___________________________ Age:_________ Phone#:____________________

Destination (countries and cities in order of itinerary)

____

Date of travel:___________________________ Length of stay:____________________________

Nature of visit: ☐ Adoption ☐ Medical ☐ Mission ☐ Safari ☐ Vacation ☐Work

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

____

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

____

Previous international travel:____

Recommended vaccines:

☐ Flu	☐ HPV	☐ Pneumonia	☐ Shingles	☐ Typhoid
☐ Hep A	☐ Meningitis	☐ Polio	☐ Td/Tdap	☐ Varicella
☐ Hep B	☐ MMR	☐ Rabies	☐ Twinrix	☐ 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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Revised 08/31/2011