



# Travel Vaccine Administration Record & Informed Consent

Travel to: \_\_\_\_\_  
(list all destinations)

Patient's Name \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_

**Last** \_\_\_\_\_ **First** \_\_\_\_\_  
 Male  Female Birth Date \_\_\_\_\_ Age \_\_\_\_\_

**Month** \_\_\_\_\_ **Day** \_\_\_\_\_ **Year** \_\_\_\_\_

Address \_\_\_\_\_  
**#** \_\_\_\_\_ **Street** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip Code** \_\_\_\_\_

Do you have health insurance?  Yes  No VFC Eligible?  Yes  No

The following questions will help us to determine which vaccines may be given today. If a question is not clear, please ask the nurse to explain it.

IS THE PERSON RECEIVING THE VACCINE...	Yes	No	Don't Know
1. Sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Allergic to latex, medications, food or any vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever had a serious reaction after receiving a vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Had a health problem with lung, heart, kidney or metabolic disease (e.g., diabetes, asthma, or a blood disorder)? Is he/she on long-term aspirin therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Between the ages of 2 and 4 years and had a healthcare provider tell you that the child had wheezing or asthma in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Been diagnosed with cancer, leukemia, AIDS or any other immune system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Taking cortisone, prednisone, other steroids, anticancer drugs or x-ray treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Been given a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin during the past year?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Had a seizure or a brain problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Received any vaccinations or TB skin tests in the past four (4) weeks or been told to get a TB skin test?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>FOR GIRLS/WOMEN 9 years old or older:</b>			
Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you trying to get pregnant in the next 28 days?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Counseled to avoid pregnancy within the next 28 days: Nurse initial _____ / Client initial _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Informed Consent:**

I have read or have had explained to me the information contained in the Vaccine Information Statement(s) about the disease(s) and the vaccine(s). I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) and request that the vaccine(s) indicated on the reverse side be given to me or to the person named above for whom I am authorized to make this request.

Signature of client (18 yrs. of age and older): \_\_\_\_\_ Initials: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of parent or guardian: \_\_\_\_\_ Initials: \_\_\_\_\_ Date: \_\_\_\_\_  
(If client is under 18 yrs. of age)

For Staff Use Only	Nurse Initials	Client Initials
1. Advised client of the full scope of travel medicine services that may be required prior to travel		
2. Advised client of services available at SNHD versus those services at Travel Vaccine Medicine referral sources		
3. Reviewed required and/or recommended travel vaccines with client and: a. Advised client of recommended travel vaccines available from SNHD b. Advised client of recommended vaccines that will require referral to their primary care provider or travel medicine specialist c. Advised client they may choose to receive all recommended travel vaccines from their primary care provider or a travel medicine specialist, or receive vaccines from SNHD & be referred elsewhere for others as recommended		
4. Reviewed key travel information with client from Travel Advisor website regarding destinations		
5. Referred client to personal healthcare provider or travel medicine clinic for a medical consult if indicated or requested		
6. Reviewed with client that additional fees may apply if services beyond what SNHD provides are needed		

**COMPLETE TOP PART ON BACK (NAME & DOB) →**

Patient's Name \_\_\_\_\_ Birth Date \_\_\_\_\_  
 Last First Month Day Year

**AREA BELOW FOR SNHD STAFF ONLY**

Vaccine	Date Given	Dose #	Mfg & Lot #	Site*	Route **	VIS Date	Administered by (Name/Title)
DTaP				LA RA LT RT	IM	5-17-07	
DT				LA RA LT RT	IM	5-17-07	
Td				LA RA LT RT	IM	1-24-12	
Tdap Adacel Boostrix				LA RA LT RT	IM	1-24-12 1-24-12	
IPV				LA RA LT RT	IM SQ	11-8-11	
HIB Ped Vax Act hib				LA RA LT RT	IM	12-16-98 12-16-98	
MMR				LA RA LT RT	SQ	3-13-08	
Varicella				LA RA LT RT	SQ	3-13-08	
MMRV				LA RA LT RT	SQ	5-21-10	
Hep A				LA RA LT RT	IM	10-25-11	
Hep B				LA RA LT RT	IM	2-2-12	
Hep A/Hep B Twinrix				LA RA LT RT	IM	10-25-11 2-2-12	
Meningococcal Menveo Menactra Menomune				LA RA LT RT	IM SQ	10-14-11 10-14-11 10-14-11	
PCV13				LA RA LT RT	IM	4-16-10	
DTaP/IPV Kinrix				LA RA LT RT	IM	5-17-07 11-8-11	
DTaP/IPV/HIB Pentacel				LA RA LT RT	IM	5-17-07 11-8-11 12-16-98	
DTaP/IPV/Hep B Pediatrix				LA RA LT RT	IM	5-17-07 11-8-11 7-18-07	
Pneumococcal Pneumovax				LA RA LT RT	IM SQ	10-6-09	
Rabies				LA RA LT RT	IM	10-6-09	
Rotavirus Rotateq Rotarix				ORAL	PO	12-6-10 12-6-10	
Flu				LA RA LT RT	IM IN		
Shingles Zostavax				LA RA LT RT	SQ	10-6-09	
HPV Gardasil Cervarix				LA RA LT RT	IM	5-3-11 5-3-11	
Smallpox				LA RA LT RT	ID		
Typhoid				LA RA	IM	5-19-04	
Yellow Fever				LA RA	SQ	3-30-11	
Newborn Screening							
Multi-Vaccine VIS						9-18-08	

Record # \_\_\_\_\_ Return Date: \_\_\_\_\_ VIS Given \_\_\_\_\_ Clerk \_\_\_\_\_ Clinician \_\_\_\_\_

Clinic Location:  Main  ELV  NLV  Hend  \_\_\_\_\_

Reviewed by: \_\_\_\_\_ RN / LPN Date: \_\_\_\_\_