

Please fill in sections A, B and C as completely as possible

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

A. Personal Information					
Last Name:		First Name:		MI:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> non-binary <input type="checkbox"/> other
Address:		City:			
Postal Code:	Email:		Cdn Citizen : yes <input type="checkbox"/> no <input type="checkbox"/>		
Home Tel:	Work Tel:	Cell		<b>Children Only</b>	
Birth Date: D      M      Y	Age:	PHN		Weight:	Consent Obtained <input type="checkbox"/>
Emergency Contact:		Phone:		Consent By: Mother <input type="checkbox"/> Father <input type="checkbox"/>	
Company/School/Organization (if applicable):				Guardian Name:	

B. Screening Checklist			C. Immunization History	
Do any of the following apply to you?	Yes	No	What vaccines have you had? Please complete only if you plan to receive vaccines today	Date
Fainted from having an injection			Tetanus/Diphtheria	
Severe reaction to immunization			Pertussis (Whooping Cough)	
Fever in the past 24 hours			Polio	
Current or planned pregnancies/Breastfeeding			Measles / Mumps / Rubella	
Immune suppression (eg. HIV, cancer, leukemia, organ transplant, steroid medication)			Chickenpox (vaccine / disease)	
History of Guillain-Barré Syndrome			Shingles (vaccine / disease)	
Received live vaccines or antiviral drugs within last 4 weeks or blood products in past year.			Flu	
Bleeding disorders			Prevnar13 / Pneumococcal 23	
Thymus disorders (Myasthenia Gravis)			Dukoral	
G6PD deficiency			Typhoid	
Disorders of the spleen / liver / kidney			Hepatitis A	
Bowel conditions: Irritable bowel syndrome/Crohn's/Colitis			Hepatitis B	
Depression, anxiety, psychosis			Meningitis	
Previous seizures/epilepsy/neurological conditions			Yellow Fever	
Heart disease/Diabetes			Japanese B Encephalitis	
Other (Note, it is important to list ALL diseases and conditions that you have):			Rabies	
			Other:	

**Allergies** (including: Eggs, bees stings, medications, yeast, gelatin, latex, antibiotics)

<b>Current Medical Conditions</b>	<b>Current Medications</b> (including prescription, herbal, over the counter, birth control pills)

- I give my permission to Travel Medicine and Vaccination Centre to inform my employer/school (if so requested) of the vaccine administration and/or TB test results.
- If vaccines are for travel, I understand that I am selecting my own vaccinations independent of medical advice. I will not have the opportunity to discuss travel health risks and current updates pertaining to the country/countries I will be visiting.

**Client Signature:** \_\_\_\_\_