Travel Health of WNC
REGISTRATION FORM

****Please note we do not file insurance for Travel Health****

PATIENT INFORMATION (PLEASE PRINT)

Patient's last name:	First:	Middle:	☐Mr. ☐Mrs.	☐Miss ☐Ms.	Marital status: Single☐ Mar☐Div☐ Sep☐Wid☐
Home phone no.( )					
Street address:					
Birth date:	Age:	Social Security no.:			Sex:☐M☐F
Email			Language:☐ English ☐ Spanish ☐Other:		Ethnicity: ☐ Latino/Hispanic ☐Other
Pharmacy	Employer		Phone		
Referred to clinic by:	☐Dr.☐Friend☐Family☐ Web ☐Other:				
Date of Departure and Return	From:	To:	Total Weeks:		
Destination:	Country	Province	County	Province	
Who will travel with you:	Name and dob: Name and dob:				
Please list any medications you are currently taking:					
IN CASE OF EMERGENCY					
Name of local friend or relative (not living at same address):			Relationship:		
Home phone no.:			Other phone no.:		

MEDICAL INFORMATION

Do you have allergies to any of the following? ☐ Eggs ☐Antibiotics ☐ Mercury(thimerosal) ☐Grasses/mold ☐Formaldehyde☐Other:

Are you being treated for leukemia, lymphoma, cancer or any other malignant disease? ☐ Yes ☐No
If yes please explain:

Are you taking any steroid drugs? ☐ Yes ☐No If yes please list medication:

Do you have a history of : ☐ deficiency of immune system ☐ anemia or any other blood disorder ☐ Diabetes ☐ Heart Disease ☐Other:
☐ Psychiatric illness(depression, psychosis, hallucinations or mania)
If any boxes are checked please explain:

Are you pregnant, suspect you may be pregnant, or trying to become pregnant? ☐ Yes ☐No

Have you taken a prophylactic drug for malaria in the past? ☐ Yes ☐No If so what drug?

Please check and date the vaccinations you have received in the past:

☐Typhoid(oral or vaccine)	☐ Hepatitis A	☐ Hepatitis B	Flu(2011) ☐ Yes☐No
☐ Yellow Fever	☐ Meningococcal	☐ Polio	
☐ Japanese Encephalitis	☐ TB skin test	☐ Pneumococcal	
☐ Td/Tdap	Other:		

I verify that all the information provided on this form is true and correct to the best of my knowledge

Signature_____ Date_____

CONSENT FOR VACCINES AND PRIVACY PRACTICES

(PLEASE DO NOT FILL OUT UNTIL DATE OF VISIT)

I have read and had explained to me the information about the vaccines I am receiving today. I have had a chance to ask questions which were answered to my satisfaction. I understand the risk and benefits of the vaccines and hereby request that the vaccines be given to me or my child. I understand that one must receive the entire series of any vaccine in order to be protected against disease. ☐ Yes ☐No

Travel Health of WNC offered to me a copy of its "Notice of Privacy Practices" ☐ Yes ☐No

Patient/Guardian printed name			
Patient/Guardian signature		*Date*	