Atlas Immunization

**Last Name:** _____ **First Name:** _____ **Date of Birth:** _____
mm / day / year

**Health Care #:** _____ **Phone:** _____ **Email:** _____

**Where did you hear about Atlas?** □ AHS □ Radio □ Online □ Doctor □ School □ Family or Friend □ Outdoor sign

**School:** _____ **Program:** _____ **Birth Country:** _____ **BCG: Y / N** **Arrival to Canada:** _____

| **Allergies:**<br>□ No □ Yes:<br><br>**Chronic Illness**:<br>□ No □ Yes: | **Regular Medications**:<br>□ No □ Yes: | **Past fainting with needles**: □ No □ Yes<br><br>**Past adverse reaction to vaccine**: □ No □ Yes<br><br>**Have you had any vaccines in the previous 4 weeks?**<br>□ No □ Yes: _____<br><br>**Have you been treated for TB? Y / N**<br><br>**Pregnant**: □ N/A □ No □ Yes<br>□ Planning □ Unsure<br>**Breastfeeding**:□ N/A □No □Yes |
|---|---|---|

_____(initial) I have read the *attached price list*, and I am aware of the prices for vaccines, prescriptions and the one-time Clinic Visit Fee per person per trip of **$48.00 ($28.00** for children 16 years of age and younger) **or** $75.00 Emergency fee (outside business hours). **If all** recommended vaccines are declined a $65.00 consultation fee will apply.

_____(initial) **Please submit your receipt (s) to your private insurance provider as you may be eligible for reimbursement**. Alberta Health/AHS **do not cover** travel immunizations. *Keep your receipts to avoid a fee for replacement*.

I consent to have vaccines and/or advice given at Atlas Immunization Services, Inc:

_____ _____
Client /Parent/Guardian Signature Todays' Date

# OFFICE USE ONLY

| Signature (Nurse): | | | Date: | |
|---|---|---|---|---|
| Date: | | Nurse:(initial) | Reviewed Health History: □ No change □ Yes: | |
| Date: | | Nurse:(initial) | Reviewed Health History: □ No change □ Yes: | |

| **Requisition:** | **Sent** | | **Received** | | **Copy to client** | | High Risk of Hep B |
|---|---|---|---|---|---|---|---|
| **Hep B sAb** | | Initials | | Initials | | Initials | Past infection □ No □ Yes |
| **Hep B sAb** | | Initials | | Initials | | Initials | Risk for TB Referral □ No |
| **Hep B sAg** | | Initials | | Initials | | Initials | □ Yes: |
| **Hep B core** | | Initials | | Initials | | Initials | Referred to TB Services □ No |
| **VZ IgG** | | Initials | | Initials | | Initials | □ Yes Date:_____ faxed |
| **X-ray** | | Initials | | Initials | | Initials | **School Forms**: Y / N |
| | | Initials | | Initials | | Initials | □ Paid Initial _____ |
| | | Initials | | Initials | | Initials | □ Pick up original □ Email |
| | | Initials | | Initials | | Initials | Date: |
| | | Initials | | Initials | | Initials | |
| | | Initials | | Initials | | Initials | |

Last Name:_____ First Name:_____ AGE:_____

| VACCINES | Date |
|---|---|
| Hep A – (Adult/ Ped) #1 | |
| Hep A – (Adult / Ped) #2 | |
| Hep B /Twinrix (Adult/Ped) #1 | |
| Hep B /Twinrix (Adult/Ped) #2 | |
| Hep B / Twinrix (Adult/Ped) #3 | |
| Hep B / Twinrix (Adult/Ped) ….#4 | |
| dTap | |
| dTap | |
| dTap | |
| MMR | |
| MMR | |
| Varicella | |
| Varicella | |
| Polio (IPV) | |
| Polio (IPV) | |
| Polio (IPV) | |
| RABIES #1 | |
| RABIES #2 | |
| RABIES #3 | |
| Shingles | |
| Shingles | |
| Varicella Disease<br>□ Yes □ No | |
| Varicella vaccine:<br>□ 1 DOSE □ 2 DOSES | |

**Nurse's Notes:**

| TB TEST TIME: | | L | R | **Other Vaccines** | **Date** |
|---|---|---|---|---|---|
| TB TEST – READING | | ____ mm | Xray | Other | |
| TB Test Time: | | L | R | Other | |
| TB Test - Reading | | ____mm | Xray | Other | |
| TB Test Time | | L | R | Other | |
| TB Test - Reading | | ___mm | Xray | Other | |