Atlas Immunization

Last Name: _____ **First Name:** _____ **Date of Birth:** _____ **Age**_____
Day/ MMM/ Year

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

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

Departure Date:	**Return Date**:	**Trip Details: (Check all that apply)**			
		□ Urban □ Rural □ Cruise	□ Hotel □ Hostel □ Private Home □ Work Camp □ Backpacking □ All Inclusive	□ Holiday □ Business □ Study □ Hajj/Umra □ Work □ Rotation	□ Visiting Friends & Relatives □ Volunteer: □ Social □ Health □ Construction
Please list visiting Country (ies):	**Please list visiting City (ies):**				
_____ _____ _____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____ _____ _____	**Allergies:** □ No □ Yes(list): **Chronic Illness**: □ No □ Yes (list):	**Regular Medications**: □ No □ Yes (list):	**Past fainting with needles**: □ No □ Yes **Past adverse reaction to vaccine**: □ No □ Yes **Have you had any vaccines in the previous 4 weeks?** □ No □ Yes List: _____ **Pregnant**: □ N/A □ No □ Yes □ Unsure □ Planning **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).
_____(initial) **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

***PLEASE NOTE**: If child is under 16 years of age:* **Print your First/Last name:** _____
Relationship to the child: □ Parent (with legal authority to consent) □ Guardian □ Other

OFFICE USE ONLY

Travel Health Consultant Signature (Nurse):			Date:	
Date:		Nurse: (initial)	Reviewed Health History: □ No change □ Yes:	
Date:		Nurse: (initial)	Reviewed Health History: □ No change □ Yes:	

Last Name:_____ First Name:_____ DOB: _____ 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	
Polio (IPV)	
dTap	
Typhoid Injectable / Oral	
Meningitis (ACYW-135)	
Meningitis B	
Meningitis B	
RABIES #1	
RABIES #2	
RABIES #3	
JEV #1	
JEV #2	
ORAL CHOLERA 2 DOSE	
ORAL CHOLERA 1 DOSE	
MMR #1	
Yellow Fever	
TB Test Time:	
TB Test – Reading	

□ No malaria risk
□ Referred to Dr.
□ Letter given: Chlor / Mef / Doxy / Mal / Azith / Cipro / Diamox
□ Supplied by Dr: Malaria /TD / Diamox
□ Discuss next visit: Chl /Mef /Dox /Mal/ Azith /Cipro/ Diamox
□ **Declined**: Malaria / Diamox/ Travelers Diarrhea

Email □ Travel Report □Maps □ Declined

Prescriptions Total; _____ Weight: _____ Kg

Prescription date: _____ No. of tabs _____ Med _____

Prescription date: _____ No. of tabs _____ Med _____

Prescription date: _____ No. of tabs _____ Med _____

Nurse's Notes:

Shingles #1			Varicella Disease □ Yes □ No	Varicella vaccine: □ 1 dose □ 2 doses
Shingles #2			Other	
Other			Other	
Other			Other	
Other			Other	
YF Exemption			Other	
L / R			Other	
mm	Initials	x-ray	Date:	Results: