



OKANAGAN HEALTH & PERFORMANCE

Travel Vaccination Clinic

104-1100 Lawrence Ave, Kelowna, BC, V1Y 6M4
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 Fax:(250) 860-2424

Pre-Travel Consultation

Date: _____

(The following information will help us provide you with the best service)

First Name _____ Initial _____ Last Name _____ Care Card # _____

Birthdate: MM _____ DD _____ YY _____ Age _____ Gender: M _____ F _____

Address _____ City _____ Prov _____ Postal Code _____

Phone: Home _____ Work _____ Cell _____

Emergency Contact _____ Phone Number _____

How did you hear about us? Referred by: _____ Phone book _____ Sign _____ Other _____

Travel History: Have you received travel health services in the past? yes no
 If yes, when? _____

Travel Itinerary: Date of departure for this trip: _____
 Purpose(s) of travel: work vacation visiting relatives student

Country (in order of travel)	Length of Stay	Rural Area?	Type of Accommodation: (cruise, resort, hotel, tent, hostel, private home)	Type of Travel (air, car, bus, boat, trekking, hitchhiking)
1.		Y N		
2.		Y N		
3.		Y N		
4.		Y N		

Health History: Age: _____

Yes No

_____ Do you have a chronic illness such as diabetes crohn's disease
 seizure disorder heart problems liver problems
 psychiatric illness (including depression &/or anxiety)?

_____ Do you have a weakened immune system due to: medication
 cancer medication or radiation Leukemia AIDS or HIV infection
 history of organ transplant?

_____ Do you have a history of thymus disorder (myasthenia gravis, thyoma,
 prior thymectomy) or DiGeorge Syndrome?

_____ Have you ever had Hepatitis or jaundice (skin & eyes turn yellow)?

_____ Have you had a previous reaction to any vaccine?

_____ Have you had any vaccines, immunoglobulin and/or blood products in the
 last ten months?

_____ Have you had an allergic "shock like" reaction to: eggs, chicken, gelatin,
 latex, sorbitol, or any antibiotics?

_____ Do you have any other serious/severe allergies or current health concerns?

_____ Are you currently on any medications?

For women:

_____ Are you pregnant or planning a pregnancy?

_____ Are you breastfeeding?

TRAVEL RISK COUNSELING: To be completed by Travel Nurse

Given: ___Health Advice for Travelers ___Travax information

- | | | |
|----------------------------------|---------------------------------------|----------------------------|
| ___Food/Water Precautions | ___Insect Diseases & Precautions | ___Sun Safety |
| ___Travelers Diarrhea | ___Rabies | ___High Altitude |
| ___Hygiene/Hand Washing | ___Swimming/Wading/Footwear | ___Deep Sea Diving |
| ___Safety/Injury Prevention | ___STD/Sexual Health | ___CD Outbreaks |
| ___Medical Care while travelling | ___First Aid/Syringe Kit | ___Traveling with Children |
| ___Insurance/Medical Coverage | ___Air Travel/Jet Lag/Motion Sickness | |

Malaria Prevention Recommendations (based on itinerary)

Malaria risk exists? ___Yes ___No

Anti-malarial medication recommendation:

First choice: _____

Alternates: _____

Vaccinations

Vaccine	Recomm'd	Declined	Date Given	Lot#	Site	Provider
Tetanus, Diphtheria						
Polio						
Measles, Mumps, Rubella						
Typhoid						
Hepatitis A (1 st)						
(2 nd)						
Hepatitis B (1 st)						
(2 nd)						
(3 rd)						
Twinrix (1 st)						
(2 nd)						
(3 rd)						
Meningococcal						
Japanese B Enceph (1 st)						
(2 nd)						
(3 rd)						
Yellow Fever						
Cholera						
TB skin test					(results)	
Rabies (1 st)						
(2 nd)						
(3 rd)						
Influenza						
Pneumococcal						
Other						

Travel Consultation Completed by: _____

___Service Fee Paid