Davis County Health Department

INTERNATIONAL TRAVEL CLINIC

Clearfield Clinic
22 South State
Clearfield, UT 84015
801-525-5020

Last Name	First Name	Middle	Date of Birth (mm/dd/yy)	Patient Age

Language	Race	Ethnicity	Gender
	☐ White ☐ Asian ☐ Black ☐ Alaskan ☐ Pacific Islander ☐ American Indian Native	☐ Hispanic ☐ Non Hispanic	☐ Male ☐ Female

Address:	City	State	Zip Code

Cell Phone #	Alternate Phone #	E-mail

Primary Health Insurance	Policy #	Insurance Policy Holder (Exact Name as listed on Card)

Insurance Policy Holder Date of Birth (mm/dd/yy)	Relationship to Patient	Home Address of Policy Holder if Different than Patient

By signing this form, I understand that Davis County Health Department expects payment at the time of service unless other billing arrangements have been made. **I understand that all charges incurred are my responsibility. If the Davis County Health Department has a contract with my insurance company, only services covered by my plan will be paid. It is my responsibility to know what my plan covers and I agree to pay any portion not covered. I understand that if the Davis County Health Department does not have a contract with my insurance company, I am responsible for all charges incurred.**

My signature indicates that I have reviewed and read a copy of the Notice of Privacy Practice (HIPAA), and have explained to me the Vaccine Information Statement (VIS) for each vaccine that I am requesting be given to the person named on this form. I authorize Davis County Health Department to contact me by phone call, text message, or email. I further release the Davis county health department from liability regarding immunization services rendered.

PRINT NAME: _____ **SIGNATURE:** _____ **DATE:** _____

Relationship: ☐ Self ☐ Parent or Guardian **Staff Initials:** _____

TRAVEL INFORMATION

Date of departure:	Date of Return:	Total Length of Trip:	# People traveling with you

List all countries to be visited	Cities to be visited in order of visits
1.	
2.	
3.	

PURPOSE OF TRIP: *(check all that apply)*	TYPE OF TRAVEL:	ACCOMODATIONS:
☐ Business/Work ☐ Missionary ☐ Visit family/friend ☐ Humanitarian ☐ Vacation ☐ Other_____	☐ Rural ☐ Guided ☐ Urban ☐ Independent	☐ Camping ☐ Hostel ☐ Friends/Family ☐ Vacation Rental ☐ Hotel ☐ Other:_____

ACTIVITIES: (*check all that apply*)

☐ Altitude >8,000ft (2500m)	☐ Caving (spelunking)	☐ Fresh water: rivers/lakes	☐ Scuba diving/snorkeling
☐ Animal contact/hunting	☐ Cruise ship travel	☐ Ocean/salt water	☐ Other _____

Name:_____

PERSONAL MEDICAL HISTORY / INFORMATION

The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

☐ **No known allergies**

List any Medication/Food Allergies

_____

_____

_____

MEDICAL DISEASES OR CONDITIONS

☐ **No medical diseases or conditions**

Check if you have/had any history of the following diseases or medical conditions

☐ Asthma/ Lung Disease	☐ Diabetes	☐ Heart Disease/Attacks	☐ Parkinson's	☐ Thymus disease/Thymectomy
☐ Blood Disorder	☐ DVT/PE/blood clot	☐ High blood pressure	☐ Pneumonia	
☐ Bell's Palsy	☐ Epilepsy/seizures	☐ HIV/AIDS	☐ Splenectomy	☐ Tendonitis
☐ Cancer	☐ Guillain-Barre	☐ Kidney/Liver Disease	☐ Stroke	☐ Other_____

MEDICATIONS

(Include prescriptions, contraceptives, vitamins, antacids, antibiotics, herbal, and over-the-counter)

☐ **No Medications**

Medication	Reason for Taking	Medication	Reason for Taking
1.		**4.**	
2.		**5.**	
3.		**6.**	

Screening Questionnaire - Please complete for the person to be vaccinated	No	Yes
Are you sick today? Explain:	☐	☐
Have you received any vaccinations in the past 4 weeks or TB test? If yes, what vaccine?:	☐	☐
Have you ever had a severe allergic reaction (anaphylaxis) to anything? List:	☐	☐
During the past year, have you received a blood transfusion, blood products, immune (gamma) globulin,or an antiviral drug?	☐	☐
Have you taken cortisone, prednisone, steroids, anti-cancer drugs, or had radiation treatment in the last three months?	☐	☐
Do you have a health condition or undergoing treatment that makes you moderately or severely immunocompromised? Ex: Cancer, HIV, organ transplant, immunosuppressive drugs or therapies, high-dose corticosteroids or others	☐	☐
Have you ever taken anti-malarial medication? If yes, what medication:_____Did you tolerate it well? ☐Yes ☐No	☐	☐
Are you at-risk for blood-borne infections such as HIV, AIDS, or Hepatitis B?	☐	☐
Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☐
Are you currently breastfeeding?	☐	☐
--- Additional Questions for COVID Vaccine ---	**No**	**Yes**
Have you received a dose of a COVID vaccine? If yes, which vaccine?	☐	☐
Have you received monoclonal antibodies or convalescent plasma for COVID to prevent or treat COVID-19?	☐	☐
Have you tested positive for COVID in the past 10 days?	☐	☐
Have you had a blood disorder, myocarditis/pericarditis, heparin-induced thrombocytopenia or Multisystem Inflammatory Syndrome?	☐	☐
Do you have dermal fillers (cosmetic medical device implants)?	☐	☐