

Please fill in sections A, B, C, and D as completely as possible

CD: _____

| A. Personal Information | | | | | | | |
|-----------------------------|--|-----------|-----------|-------------|---|---|--|
| Last Name: | | | | First Name: | | | MI: |
| Address: | | | | City: | | | Sex: <input type="checkbox"/> M <input type="checkbox"/> F |
| Postal Code: | | Email: | | | Cdn Citizen : yes <input type="checkbox"/> no <input type="checkbox"/> | | |
| Home Tel: | | Work Tel: | | Cell | | Children Only | |
| Birth Date: D M Y | | Age: | Carecard: | | Weight: | Consent Obtained <input type="checkbox"/> | |
| Emergency Contact: | | | Phone: | | Consent By: Mother <input type="checkbox"/> Father <input type="checkbox"/> | | |
| Family Doctor: | | | Phone: | | Guardian Name: | | |

| B. Travel Itinerary | | | | | | | | |
|--------------------------------|----------|----------------|----------------------|---|-----------------|---------------------|-----------------------------|---------|
| Date of Departure: D M Y | | | | Purpose of trip: Vacation- tour, adventure, cruise Work, Service Other: | | | | |
| Area of Travel | | | | Food and Accommodation | | | | Comment |
| Country | Duration | Urban (Cities) | Rural (Country side) | Business 1 st Class | Tourist Package | Backpack Low Budget | Home stay Friends Relatives | |
| | | | | | | | | |
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| C. Medical History | | | D. Immunization History | | |
|--|--|-----|-------------------------|---------------------------------|------|
| Do any of the following apply to you? | | Yes | No | What vaccines have you had? | Date |
| Fainted from having an injection | | | | Tetanus/Diphtheria | |
| Severe reaction to immunization | | | | Polio | |
| Fever in the past 24 hours | | | | Measles/Mumps/Rubella | |
| Current or planned pregnancies/Breastfeeding | | | | Typhoid | |
| Immune suppression (eg. HIV, cancer, leukemia, organ transplant, steroid medication) | | | | Hepatitis A | |
| History of Guillain-Barré Syndrome | | | | Hepatitis B | |
| Received blood products in past year | | | | Yellow Fever | |
| Bleeding disorders | | | | Japanese B Encephalitis | |
| Thymus disorders (Myasthenia Gravis) | | | | Meningitis | |
| G6PD deficiency | | | | Rabies | |
| Disorders of the spleen / liver / kidney | | | | Flu/Pneumococcal 23 | |
| Bowel conditions: Irritable bowel syndrome/Crohn's/Colitis | | | | Pertussis (Whooping Cough) | |
| Depression, anxiety, psychosis | | | | Chickenpox (vaccine or disease) | |
| Previous seizures/epilepsy/neurological conditions | | | | Dukoral | |
| Heart disease/Diabetes | | | | Shingles (Zostavax) | |
| Other (Note, it is important to list ALL diseases and conditions that you have): | | | Other: | | |

Allergies (including: Eggs, Bee Stings, Medications, Yeast, Gelatin, Latex):

| | |
|-----------------------------------|--|
| Current Medical Conditions | Current Medications including prescription, herbal, over the counter, birth control pills |
| | |