

Medical Information (continued)

Are you allergic to any of the following? No

- | | | |
|---|---|--|
| <input type="checkbox"/> Eggs (describe reaction):
_____ | <input type="checkbox"/> Thimerosal or Aluminum | <input type="checkbox"/> Formaldehyde or Phenol |
| <input type="checkbox"/> Food (describe reaction):
_____ | <input type="checkbox"/> Neomycin | <input type="checkbox"/> Have you had an adverse reaction to an anti-malarial? |
| <input type="checkbox"/> Wasp/Insect bites | <input type="checkbox"/> Sulfa, Sulfamycin, Bactrim, Septra | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Wasp/Insect bites | <input type="checkbox"/> Penicillin | _____ |
| | <input type="checkbox"/> Tetracyclines | _____ |

Itinerary

Departure date / / Duration of the trip _____ days _____ weeks _____ months
DD MM YY

Please list all countries and regions you will visit (including stop overs) during your trip

Countries to be visited	Urban areas/Duration	Rural areas/Duration
1		
2		
3		
4		
5		
6		
7		

Purpose of trip

- | | | |
|--|--|--|
| <input type="checkbox"/> Pleasure/holiday | <input type="checkbox"/> Education/study/summer camp | <input type="checkbox"/> Business (specify type of work):
_____ |
| <input type="checkbox"/> Visiting family/friends | <input type="checkbox"/> Volunteer work | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Adoption | <input type="checkbox"/> Religious visit | _____ |

Where will you be staying?

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> 1 st class hotel, resort or cruise ship | <input type="checkbox"/> Camping | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Budget hotels and/or hostels | <input type="checkbox"/> Company lodge | _____ |
| <input type="checkbox"/> Inns/B & B | <input type="checkbox"/> Family/Friends | _____ |

Possible activities

- | | | |
|--|---|--|
| <input type="checkbox"/> Healthcare activities | <input type="checkbox"/> Wilderness activities/extreme sports | <input type="checkbox"/> Safari |
| <input type="checkbox"/> Volunteer/humanitarian activities | <input type="checkbox"/> High altitude activities/climbing | <input type="checkbox"/> Jogging, running, bicycling |
| <input type="checkbox"/> Activities involving contact with animals | <input type="checkbox"/> Rafting/water sports | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Veterinary activities | <input type="checkbox"/> Underwater diving | _____ |
| | | _____ |

Immunization History

Name _____

I have not had any vaccinations in the past 10 years

Vaccine	Date of Injections	Vaccine	Date of Injections
<input type="checkbox"/> DT (Diphtheria/Tetanus)	_____	<input type="checkbox"/> Polio	_____
<input type="checkbox"/> DT aP (Adacel)	_____	<input type="checkbox"/> Pneumococcal	_____
<input type="checkbox"/> DTP (Dipht./Tet./Polio)	_____	<input type="checkbox"/> Rabies	_____
<input type="checkbox"/> Hepatitis A	_____	<input type="checkbox"/> TBE vaccine	_____
<input type="checkbox"/> Hepatitis B	_____	<input type="checkbox"/> Typhoid fever	_____
<input type="checkbox"/> Hepatitis A & B combo	_____	<input type="checkbox"/> Yellow fever	_____
<input type="checkbox"/> Hepatitis A/Typhoid combo	_____	<input type="checkbox"/> Zoster (shingles)	_____
<input type="checkbox"/> HPV (Gardasil, Cervarix)	_____	<input type="checkbox"/> Antimalarial medication	_____
<input type="checkbox"/> Influenza	_____	<input type="checkbox"/> Tick borne encephalitis	_____
<input type="checkbox"/> Japanese encephalitis	_____	<input type="checkbox"/> Dukoral (Cholera & travellers diarrhea)	_____
<input type="checkbox"/> Meningitis	_____	<input type="checkbox"/> Varicella (Chicken Pox)	_____
<input type="checkbox"/> MMR	_____	<input type="checkbox"/> Others: _____	_____
		_____	_____
		_____	_____

Did you have any of the following diseases in your childhood?

Varicella (Chicken Pox) Mumps Measles Other: _____

Have you ever had an adverse reaction to a vaccine?

Please specify: _____

