Travel Vaccine Administration Record & Informed Consent

Traveling to: _____
(List all destinations to include City and Region if known)

Departure Date: _____ **Length of Stay:** _____

Patient's Last Name _____ **First Name** _____ **Age:** _____

Patient Emergency Contact: (For emergency only such as passing out or needing to be taken to a hospital)

Name _____ **Relationship**: _____ **Phone Number:** _____

Language most comfortable speaking: _____ **Do you need an interpreter?** ☐ **Yes** ☐ **No**

Hearing impaired or need sign language interpreter services? ☐ **Yes** ☐ **No**

I ACKNOWLEDGE THAT A COPY OF THE "NOTICE OF PRIVACY PRACTICE" HAS BEEN MADE AVAILABLE TO ME _____ (INITIAL)

SNHD STAFF ONLY/ VFC Eligibility: ☐ **Not Eligible** ☐ **Uninsured/Underinsured** ☐ **Native American or Alaskan Native** ☐ **NV Medicaid** ☐ **NV Check-Up**

Complete the following questions to help us determine which vaccines may be given today.
If a question is not clear, please ask the nurse to explain it.

IS THE PERSON RECEIVING THE VACCINE:	**Yes**	**No**	**Don't Know**
1. Sick today?	☐	☐	☐
2. Allergic to latex, medications, food or any vaccine?	☐	☐	☐
3. Ever had a serious reaction after receiving a vaccine?	☐	☐	☐
4. Had a health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, or a blood disorder? Is he/she on long-term aspirin therapy?	☐	☐	☐
5. Between the ages of 2 and 4 years and had a healthcare provider tell you that the child had wheezing or asthma in the past 12 months?	☐	☐	☐
6. Been diagnosed with cancer, leukemia, AIDS, HIV or any other immune system problem?	☐	☐	☐
7. Taking cortisone, prednisone, other steroids, anticancer drugs or x-ray treatments?	☐	☐	☐
8. Been given a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin during the past year?	☐	☐	☐
9. Had a seizure or a brain problem?	☐	☐	☐
10. Received any vaccines or TB skin tests in the past 4 weeks or been told to get a TB skin test?	☐	☐	☐
FOR FEMALES 9 years old or older: Are you pregnant?	☐	☐	☐
Are you trying to get pregnant in the next 28 days?	☐	☐	☐
☐ Counseled to avoid pregnancy within the next 28 days: Nurse initial_____/Client initial_____			

Informed Consent*: I answered all the questions correctly to the best of my knowledge. I have read or have had explained to me the information contained in the Vaccine Information Statement(s) about the disease(s) and the vaccine(s). I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) and request that the vaccine(s) indicated on the reverse side be given to me or to the person named above for whom I am authorized to make this request.*

SIGN HERE: _____ **Date:** _____

☐ Client (18 years of age and older) ☐ Parent/Guardian

For Staff Use Only	**Nurse Initials**	**Patient Initials**
1. Reviewed key travel information from the CDC website on Traveler's Health.		
2. Reviewed required and/or recommended travel vaccines with patient and: a. Advised patient of required/ recommended travel vaccines; b. Advised patient of required/recommended vaccines that require a patient to follow up with their primary care provider or a travel medicine specialist; c. Advised patient they may choose to receive all recommended travel vaccines from their primary care provider, a travel medicine specialist or SNHD.		
3. Advised patient that SNHD does not provide the following services: prescription for malaria, diarrhea, altitude sickness or oral typhoid vaccine, yellow fever exemption letter, blood work to determine immunity, other necessary medical services. Advised that if any of these are needed, patient needs to contact their primary care provider or travel medicine specialist.		
4. Patient requested the following vaccines: _____		

Patient's Name_____ **Birth Date**_____

Last First Month Day Year

AREA BELOW FOR SNHD STAFF ONLY							
Vaccine	Date Given	Dose #	Mfg & Lot #	Site*	Route **	VIS Date	Administered by (Name/Title)
DTaP				LA RA LT RT	IM	08-06-21	
DT				LA RA LT RT	IM	08-06-21	
Td				LA RA LT RT	IM	08-06-21	
Tdap				LA RA LT RT	IM	08-06-21	
IPV				LA RA LT RT	IM SQ	08-06-21	
HIB				LA RA LT RT	IM	08-06-21	
MMR				LA RA LT RT	SQ	08-06-21	
Varicella				LA RA LT RT	SQ	08-06-21	
MMRV				LA RA LT RT	SQ	08-06-21	
Hep A				LA RA LT RT	IM	10-15-21	
Hep B				LA RA LT RT	IM	10-15-21	
Hep A-Hep B **Twinrix**				LA RA LT RT	IM	10-15-21 10-15-21	
MenACWY MenB				LA RA LT RT LA RA LT RT	IM IM	08-06-21 08-06-21	
PCV				LA RA LT RT	IM	02-04-22	
DTaP-IPV				LA RA LT RT	IM	08-06-21 08-06-21	
DTaP-IPV/HIB **Pentacel** **Vaxelis** DTaP-IPV-HIB-HepB				LA RA LT RT	IM	08-06-21 08-06-21 08-06-21 10-15-21	
DTaP-IPV-Hep B **Pediarix**				LA RA LT RT	IM	08-06-21 08-06-21 10-15-21	
PPSV23 **Pneumovax**				LA RA LT RT	IM SQ	10-30-19	
Rabies				LA RA LT RT	IM	01-08-20	
Rotavirus				ORAL	PO	10-15-21	
Flu				LA RA LT RT	IM IN	08-06-21	
Shingles				LA RA LT RT	IM	02-04-22	
HPV				LA RA LT RT	IM	08-06-21	
Cholera				ORAL	PO	10-30-19	
Typhoid				LA RA	IM PO	10-30-19	
Yellow Fever				LA RA	SQ	04-01-20	
Japanese Enceph				LA RA LT RT	IM	08-15-19	
COVID-19				LA RA LT RT	IM		
Multi-Vaccine VIS						10-15-21	

Record # _____ Return Date: _____ VIS Given _____ _____

Clerk Clinician

Clinic Location: ☐ Main ☐ ELV ☐ Hend ☐ Mesquite ☐ Employee Health ☐ Other _____

Reviewed by: _____ RN / LPN Date: _____