Takoma Park Travel Clinic
7610 Carroll Ave, Ste. 400, Takoma Park, MD 20912
Tel (301) 891-6141 Fax (301) 891-6841

REGISTRATION FORM

PLEASE PRINT CLEARLY

Name of person completing form _____ **Relationship to patient*** _____

**For children: If you are not child's parent or legal guardian please inform parent they must be present to sign legal documents.*

A. PATIENT INFORMATION

LAST Name _____ Date of Birth ___/___/___

First Name _____ Gender **FEMALE / MALE / TRANS**

Middle Name _____ Email _____

Address _____

APT # _____ ***HOW DID YOU HEAR ABOUT OUR CLINIC?***

City _____

Zip Code _____ State _____

Race(s) or ethnic background(s) _____ Language _____

B. CONTACT INFORMATION

Phone #1 _____ (Circle one) **Cell / Home / Work**

Phone #2 _____ (Circle one) **Cell / Home / Work**

Phone #3 _____ (Circle one) **Cell / Home / Work**

Emergency Contact

Name _____

Phone # _____

➢ FOR CHILDREN: PARENT / GUARDIAN Information

☐ **Not Applicable** *(go to next section)*

Last Name _____ **Relationship to child** _____

First Name _____ Legal guardian? **YES / NO**

Address (if different than child's) _____ Email _____

Phone number *(if different from above)* _____

Employed by _____ Full-Time Student? **YES / NO**

DOB _____ SSN _____ Financially responsible for child? **YES / NO**

Authorized to bring patient to office, discuss medical information and make medical decisions? **YES / NO**

C. TRAVEL INFORMATION *(If not traveling, go to C1.)*

REASON FOR TRAVEL

☐ Visiting friends or family ☐ Business

☐ Vacation/Recreation ☐ Mission trip

☐ Other

DEPARTURE DATE _____

RETURN DATE _____

CITIES & COUNTRIES to be visited *(ex. Addis Ababa, Ethiopia)* LENGTH OF STAY

_____ _____

_____ _____

_____ _____

_____ _____

Accommodations ☐ Staying with family/friends ☐ Hotel ☐ Hostel ☐ Outdoor/Camping ☐ Other _____

Do you plan to travel outside of urban areas?	NO	YES
Do you plan to drive? *(Includes car, motorcycle, scooter, etc.)*	NO	YES
Are you planning to go hiking, back-packing, or diving?	NO	YES
Will you be seeing the travel medicine doctor for consultation today?	NO	YES
C1) Have you ever received any of the following? Give date of last dose.	NO	YES

☐ Yellow Fever _____ ☐ Meningococcal _____ ☐ Malaria Prescription

☐ Typhoid _____ ☐ Hepatitis A _____ _____

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D. HEALTH INFORMATION & MEDICAL HISTORY

Are you current on all of you regular vaccines?	NO*	YES
**If NO or DON'T KNOW, please contact you primary care doctor to verify that you are up-to-date on all of your regular vaccines.*		

Do you have allergies to any of the following?	**NO**	**YES**

☐ **Bee stings** ☐ **Gelatin** ☐ **Egg allergy** ☐ **Thimerosal (Mercury)**

☐ **Medications, please list** _____

Are you currently taking any medications?	NO	YES
If YES, please list and indicate use. *(ex. Lipitor for cholesterol)*		

Have you ever had an adverse reaction to a vaccine?	NO	YES
If YES, please describe.		

Are you nursing?	N/A	NO	YES
Are you pregnant or trying to get pregnant?	N/A	NO	YES
Do you have a history of immune disorder such as lupus, cancer, or HIV?		NO	YES
Do you live with someone who is taking prednisone, steroids, or chemotherapy?		NO	YES
Do you live with someone who has cancer or HIV?		NO	YES

Do you have any of the following conditions?

Heart trouble	NO / YES	Mental Illness	NO / YES	Diabetes	NO / YES
High blood pressure	NO / YES	Depression	NO / YES	Bleeding disorder	NO / YES
Lung disease	NO / YES	Seizure disorder	NO / YES	Take anticoagulants	NO / YES
Asthma	NO / YES	Epilepsy	NO / YES		

E. CONSENT & AGREEMENT

I have received the Centers for Disease and Prevention (CDC) recommendations, if applicable, and understand that the CDC recommends the listed vaccines for my destination. I have received Vaccine Inventory Statements (VIS) for the vaccines I have chosen. I understand that Advisory Committee on Immunization Practices (ACIP) recommends waiting in the office for 15 minutes after vaccination administration; I also understand that by leaving the office before the recommended 15-minute waiting period, I do so at my own risk. **(CIRCLE ONE)** I have **chosen / declined** to see the travel medicine doctor. **BY SIGNING BELOW, I CERTIFY THAT THE INFORMATION I HAVE PROVIDED ABOVE IS CORRECT AND ACKNOWLEDGE THAT TAKOMA PARK TRAVEL CLINIC DOES NOT PARTICIPATE WITH INSURANCE COMPANIES.**

Patient Signature _____ Today's Date _____

Patient Printed Name _____