Chautauqua County Department of Health
Travel Immunization Clinic Intake Form

PLEASE COMPLETE ENTIRE FORM FOR PERSON TO RECEIVE IMMUNIZATIONS

*Information about the person to receive vaccine (**Please Print**):*

Has person ever attended a Chautauqua County Immunization Clinic before? ☐ Yes ☐ No					
First Name:		Middle Name:	Last Name:		Maiden Last Name:
Birth Date(DOB):	Age:	Sex: ☐ M ☐ F	Country of Birth:	Has person received any vaccinations under a different last name? If Yes, enter name:	
Mother's name: First: Last (maiden):				If person being immunized is a twin or triplet please check birth order: ☐ 1 ☐ 2 ☐ 3	
Who is responsible for the person getting vaccinated? Please check one of the following: ☐ Self ☐ Mother ☐ Father ☐ Guardian ☐ Other relative ☐ None of the above Name of responsible person (if not self) First: Last:					
Phone Number: ( )			Street Address:		
City:			State:	Zip:	
Person being immunized: ☐ Has Medicaid/Medicaid managed care ☐ Insurance covers immunizations ☐ Not Insured/No Insurance/ Insurance does not cover immunizations					
Name of Doctor and address:			Race (check one box): ☐ American Indian/Alaskan ☐ Hispanic ☐ Asian or Pacific Islander ☐ Black, not of Hispanic origin ☐ White, not of Hispanic origin ☐ Other or Unknown		
			If 19 years of age or older, has consent been given for immunizations to go into NYS Information System? ☐ Yes ☐ No ☐ I don't know		

Medical Information about the person to receive vaccine:

Please answer each question by checking (X) in appropriate box	Yes	No	Don't Know
Is the person being immunized sick today?			
Does the person being immunized have allergies to medications, food, or any vaccine?			
Has the person being immunized had a serious reaction to a vaccine in the past?			
Has the person being immunized had a seizure, a brain problem, or Guillain-Barré syndrome?			
Does the person being immunized have cancer, leukemia, AIDS, or any other immune system problem?			
Has the person being immunized taken cortisone, prednisone, other steroids, or anticancer drugs, or had x-ray treatments in the past 3 months?			
Has the person being immunized received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin in the past year?			
Is the person being immunized pregnant or is there a chance she could become pregnant during the next month?			
Has the person being immunized received any vaccinations in the past 4 weeks?			
Has the person being immunized have a history of thymus problems such as myasthenia gravis or DiGeorge syndrome; or had the thymus gland removed?			

TRAVEL IMMUNIZATION WORKSHEET

Patient Name: _____ Date of Birth: _____ Age: _____

The signature below confirms that I have been given a copy and have read, or have had explained to me, information about the disease(s) and vaccine(s) to be received. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) requested and ask that the vaccine(s) be given to me or to the person named above for whom I am authorized to make this request.

Administered Vaccines

Vaccination/VIS Date Given: _____ Facility: _____

Vaccinator and Title: _____

Vaccine (specify)	Mfg & Lot#	Vaccine Source	INJ Site	VIS Print Date	Patient/ Parent Signature
Hep A					
Hep B					
Influenza					
IPV					
Japanese Encephalitis					
Meningococcal					
MMR	MMR: Diluent:				
Pneumococcal					
Rabies					
Td					
Tdap					
Twinrix					
Typhoid					
Varicella	Var: Diluent:				
Yellow Fever	YF: Diluent:				