The Village Drug Shop Travel Clinic – Travel Health & Immunizations
740 Prince Ave, Athens, GA 30606
Ph: 706-548-4444 Fax: 706-548-2193

TRAVEL MEDICINE PATIENT DEMOGRAPHICS

Patient's Full Name: ______________________________ DOB:________________ Sex:________

Address: ____

Home Phone: __________________ Cell: __________________ Email:________________________

Marital Status:________________ Spouse's Name: ____

Preferred Pharmacy Name:________________________Pharmacy Phone: _______________________

Emergency Contact: _____________________________________Relation:______________________

Address: _______________________________________Phone:__________________________

Primary Care Physician:____

PCP Address:____

PCP Phone: _____________________________ PCP Fax: _____________________________

THE VILLAGE DRUG SHOP TRAVEL CLINIC
HIPAA PRIVACY CONSENT

By initialing below the above named patient or the guardian of the patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a "Notice of Privacy Practices" document and the patient/guardian has the opportunity to review this notice
- The Practice reserves the right to change the Notice of Privacy Practices at any time
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent

Initials: __________ Date: _______________________

FINANCIAL POLICY

By initialing below I attest that I understand and agree to the following regarding fees for services provided by The Village Drug Shop – Travel Health & Immunizations Clinic (VDS Travel Clinic):

- **A $100 non-refundable fee will be charged for the development of a comprehensive individualized plan, coordination with your physician, and vaccine administration. Please provide credit card information below or provide check with completed travel forms.**
- Total claims/fees for services provided by the VDS Travel Clinic are to be paid in full at time of services rendered.
- The VDS Travel Clinic will submit claims/fees for services provided to health insurance carriers. If insurance reimbursement is less than cost of medications/immunizations plus administration fees, then the patient will be responsible to make up the difference.

Initials: __________ Date: _______________________

Cardholder Name: _________________________________

Type of Card: ____________________________________

Credit Card Number: ______________________________

Expiration Date: _________________________________

CCV Code: _______________________________________

Zip Code: ____

DOCUMENT CONTINUED ON NEXT PAGE

INSURANCE INFORMATION

You may **SCAN OR TAKE PHOTO** to email insurance card information
OR include info below:

Name of Insurance: ____

Cardholder name: ____

Prescription or Member **ID** number: ____

Prescription **Rx BIN** number: ____

Prescription **Rx Group** number: ____

Prescription **Rx PCN** number: ____

REFUSAL OF RECOMMENDED IMMUNIZATIONS

By initialing bellowing I attest that I understand the risks and benefits of the immunizations that were recommended to me by the Village Drug Shop Travel Clinic. I understand that vaccination/immunizations from illness or disease is voluntary. For any reason, if I chose not to accept the recommended immunizations, I do not hold the Village Drugs Shop or any of its personnel accountable for any risks incurred for being unvaccinated and unprotected from potential illness or disease.

Initials: ____________ Date: ______________________

CONSENT TO EMAIL COMMUNICATION

I understand that electronic communication through potentially unsecure internet connections or email providers may harbor the chance personal health information may be intercepted by individuals or parties not affiliated with my health care. I agree to communicate via email (if applicable) with VDS Travel Clinic. If you choose not to do so your process time may be slower to account for postal delivery or in-person pick up of travel forms. By initialing below, I herby consent to communicating via electronic mail with VDS Travel Clinic:

Initials: ____________ Date: ______________________

CONSENT TO TREAT

I understand the interactions, allergies, warnings, precautions, and potential adverse reactions regarding the medications and immunizations that I received at the Village Drug Shop Travel clinic. I have read the information on the vaccine information statement sheet (VIS from the CDC) and understand the information. I voluntarily consent to receive the medications and/or immunizations.

By signing below, I hereby consent to evaluation, testing and treatment for me or the above named patient as directed by the physician or his or her designee at the VDS Travel Clinic. By signing below, I certify I have read and understand and agree to the content on this page including the HIPAA PRIVACY CONSENT, FINANCIAL POLICY, REFUSAL OF RECOMMENDED IMMUNIZATIONS, AND CONSENT TO TREAT.

Signed: ______________________________________ Date: ______________________

This form/consent was signed by (Printed name): ______________________________________

Relationship of the person who signed for the patient: ______________________________________

Witness from VDS Travel Clinic: (Print, Sign, Date): ______________________________________

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INTERNATIONAL TRAVEL MEDICAL QUESTIONNAIRE

Exact Name on Passport: ____

Today's Date: ____________________________ Date of Birth: ___________________ Sex: _____________

Travel Itinerary (Country or countries): Please list in order of visit

Country & City/location	Arrival date	Depart date	Describe: urban or rural, activities, lodging plans

Reason for travel (circle all that apply): Mission Vacation Business Education Medical Other

List all allergies, sensitivities, medications, foods, etc. If none, please indicate by checking the box below:

Latex?____ **NO allergies or sensitivities**:

Have you ever had any reaction or side effect from any vaccination? Yes or No

If yes, explain: ____

Medication History: Please list all the medications you are currently taking, including over the counter medications, vitamins and minerals, and herbal supplements. You may continue to list on page 2 if necessary.

Medical History: Please circle yes or no answer for each question below

Are you currently ill (fever, headache, fatigue, nausea, vomiting, or diarrhea)?	Yes	No
Have you ever fainted from having your blood drawn or from an injection?	Yes	No
Do you live (or work closely) with anyone who has a deficiency of the immune system?	Yes	No
Do you have any deficiency of the immune system, or are you taking steroids, chemotherapy?	Yes	No
Is there a possibility you may be pregnant?	Yes	No
Do you currently have a fever over 101 degrees orally or an acute illness?	Yes	No
Are you on any anticoagulation medications or blood thinners?	Yes	No
Do you have a thymus disorder (thymomas, myasthenia gravis, thymectomy)?	Yes	No
Have you had a blood transfusion or Immune globulin in the past 6 months?	Yes	No
Have you had any surgical procedure in the past 6 months?	Yes	No
Do you have an allergy to egg, chicken protein, or gelatin?	Yes	No

Have you had or do you have any of the following conditions: Check all that apply

Fever in past 48 hours
Diabetes
Asthma / COPD
Psoriasis
Stomach / bowel problems
Kidney disease
Thyroid disease
High cholesterol

High blood pressure
Folic Acid deficiency
Liver disease
Rheumatoid arthritis
Eye disease / condition
Cancer, chemo, radiation
Joint swelling
Stroke

Heart disease (irregular heart beat)
Convulsions, seizures, epilepsy
Low platelet count/coag. Disorder
Tuberculosis / Lung disease
Depression/anxiety/psychiatric problems
Insomnia, nightmares
Numbness, tingling, weakness
Blood clots

Do you use tobacco currently or in the past? Yes or No   If yes, how many packs/cans per day? ________

Do you drink alcohol? Yes or No If yes, how many beverages (12 oz beer, 5 oz wine, or 1.5 oz liquor) per week? ____

Previous Vaccination History: Please indicate if you have ever received any of the following vaccinations by checking the appropriate box. If you have received any of the vaccinations below, please indicate what year they were administered:

Hepatitis A: I have received in the past – Yes or No If yes: Did you receive 2 doses? Yes or No	**Hepatitis B**: I have received in the past – Yes or No If yes: Did you receive 3 doses? Yes or No
Tetanus: I have received in the past – Yes or No Date received: ___________________	**Typhoid**: I have received in the past – Yes or No Date received: ___________________
MMR (Measles, Mumps, Rubella): I have received in the past – Yes or No	**Yellow Fever:** I have received in the past – Yes or No Date received: __________________
Polio: I have received in the past – Yes or No Have you received this as an adult? Yes or No	**Meningitis**: I have received in the past – Yes or No Date received: ____________________
Japanese Encephalitis: I have received in the past – Yes or No	**Rabies**: I have received in the past – Yes or No
Influenza: I have received in the past – Yes or No (flu shot) Date received: ___________________	**ZostaVax**: I have received in the past – Yes or No (shingles) Date received: ____________________

To the best of my knowledge, the questions on this form (pages 1 and 2) have been accurately answered. I understand that the information I provided above is used to for my medical health assessment in determining if medical services received by the Village Drug Shop Travel Clinic are safe and appropriate based on my current health status. I understand that providing incorrect information can lead to a delay in diagnosis and can be dangerous and potentially fatal to my health. It is my responsibility to inform the doctor's office of any change in my medical status.

____ _____________________________
Signature of patient or legal guardian Date

____
Printed name of signature, if it is not the named patient

____ _________________________
Signature of Witness Date

____
Printed name of Witness