Travel Consult	Patient's Name _____ Last Name First Name		
Today's Date: / /	Birth Date: / /	Age	☐M ☐F

PAYMENT GUARANTEE

Payment for services rendered at this travel consult is required at the time of service. We accept payment by check or credit card. Insurance coverage for travel consults greatly. Your visit will be billed as an outpatient service with a primary diagnosis of Z71.89, "Other Specified Counseling". Please call your insurance carrier **PRIOR** to your appointment to verify coverage. If this is a covered service we will file your claim with your insurance carrier. Advocare Morristown Pediatric Associates will bill you for any charges not covered after being sent to your carrier. Please keep in mind that the billing of insurance is a courtesy to you. Your insurance policy is a contract between you and your insurance company. Communication with your insurance company is your responsibility.

I ACCEPT THE PAYMENT TERMS AS DETAILED ABOVE:

Patient/Parent/ or Guarantor Signature: _____ Date: _____

MEDICAL HISTORY

1. **Does your child have any medication allergies?** □ NO □ YES
2. **If yes, please list any known allergies here:** _____
3. **Is your child allergic to any of the following? Please select all that apply.**

□ 2-phenoxyethanol
□ Aluminum or aluminum hydroxide
□ Amphotericin B
□ Aminoglycosides (ex: neomycin, streptomycin, gentamicin)
□ Bee stings or have a history of hives with bee sting
□ Beef protein, soy casein, lactose, phenol, or formaldehyde
□ Eggs
□ Chicken
□ Gelatin
□ Latex
□ Mercury or thimerosal
□ Polymixin
□ Sulfites
□ Sulfa
□ Yeast
□ Other_____
□ None of these

4. **Do any of the following health conditions apply to your child? Please select all that apply**

□ Allergies
□ Asthma
□ Anti-coagulation therapy (Coumadin)
□ Cancer (type) _____
□ Diabetes
□ Fever (in last 48 hours)
□ Heart disease
□ HIV/AIDS
□ Immune compromised
□ Pregnant or suspect you may be pregnant
□ Breastfeeding
□ Psychiatric Disorder
□ Seizures
□ Stomach disorder (GERD/peptic ulcer disease)
□ Thymus disorder (eg: myasthenia gravis, Di George syndrome, thymoma, or thymus removal)
□Other_____
□ NONE of these apply

5. **Is your child currently taking any medications?** □ YES □ NO
6. **If YES, please list all current prescription medications, Over the counter medications, Vitamins, and herbal supplements**

_____
_____

I attest that all of the information above is to the best of my knowledge and belief true, correct and complete.

Patient/Parent/ or Guarantor Signature: _____ Date: _____

Patient Name:_____ DOB:_____ Today's date: _____

7. **Is your child up to date on his/her routine vaccinations?** ☐ NO ☐ YES ☐ I Don't know

8. **Date of last flu vaccine:** _____

9. **If your child has had any of the following vaccines in the past, please check and list approximate dates**

□ Immune Globulin _____
□ Japanese Encephalitis _____
□ Rabies _____
□ Typhoid _____
□ Yellow Fever _____
□ My child has never had any of the above vaccines

10. **Has your child ever had any reaction to a vaccine?** ☐ NO ☐ YES
11. **If YES, please list the vaccine and describe the reaction** _____
_____
_____

I attest that all of the information above is to the best of my knowledge and belief true, correct and complete.

Patient/Parent/ or Guarantor Signature: _____ Date: _____

Patient Name:_____ DOB:_____ Today's date: _____

TRAVEL ITINERARY

Date of departure: _____ **Date of return**:_____

1. **Please list each country and city that you are planning to visit and include the length of each stay:**

Country	City	Length of stay

2. **Will you be spending time in any additional cities/countries during transit to your final destination (for example: a layover in another airport)** □ NO □ YES
3. **If Yes, please list which city/country and how long you expect to be there** _____
_____

4. **What type of places do you plan to visit? Select all that apply:**

□ City and urban areas
□ Rural areas – staying in hotels
□ Rural areas- camping
□ Hiking
□ Beaches
□ Tropical jungle
□ High altitude (over 4000 feet)
□ Snow/mountainous terrain
□ Other: _____
_____

5. **What is the purpose of your travel:**

□ Business
□ Pleasure/Vacation
□ Visiting family/friends
□ Study abroad
□ Humanitarian

6. **Please select the geographic areas that your child has traveled to in the past three years. Select all that apply.**

□ Africa
□ Asia
□ Central/South America
□ Europe/Australia
□ India
□ Other: Please specify_____
□ I have not traveled outside of the United States.

I attest that all of the information above is to the best of my knowledge and belief true, correct and complete.

Patient/Parent/ or Guarantor Signature: _____ Date: _____

Patient Name:_____ DOB:_____ Today's date: _____

Vaccine Administration Record of Consent & Refusal to Vaccinate

Vaccines Recommended today	Not Available	Contraindicated	Declined	Accepted
☐ **Typhoid**	☐	☐	☐	☐
☐ **Japanese Encephalitis**	☐	☐	☐	☐
☐ **Yellow Fever**	☐	☐	☐	☐
☐ **Rabies**	☐	☐	☐	☐
☐ **Influenza**	☐	☐	☐	☐
☐ **Meningitis**	☐	☐	☐	☐
☐ **Other:_____**	☐	☐	☐	☐

Malaria Prophylaxis

☐Recommended ☐Not indicated at this time

Medication Prescribed: _____
Dose: _____

Patient/parent was counseled on malaria prophylaxis. Proper use of medication and side effects discussed.

Information about the diseases and the vaccines checked above has been explained to me. I have had a chance to ask questions which were answered to my satisfaction.

I understand the following:

- The purpose and the need for the recommended vaccine(s)/prophylaxis
- The risks and benefits of the recommended vaccine(s)/prophylaxis
- My medical provider, the American Academy of Pediatrics, the American Academy of Family Physicians, and the Centers for Disease Control and Prevention strongly recommend that the vaccine (s) be given according to recommendations, unless a medical contraindication check above prevents a vaccine opportunity today.
- If the vaccine(s)/prophylaxis are not received according to these recommendations, consequences may include:
    - Contracting the illness the vaccine should prevent. The outcomes of these illnesses may include one or more of the following: illness requiring hospitalization, brain damage, meningitis, or death. Other severe and permanent effects from the vaccine-preventable diseases are also possible.
    - Transmitting the disease to others
    - Requiring the patient to stay out of child care or school during disease outbreak.

If the recommended vaccine above is checked as:

- *Not available:* I will seek the vaccine elsewhere or reschedule visit as advised
- *Contraindicated:* I understand why the vaccine should not be given today (or ever) or if I should reschedule
- *Declined*: I refuse the vaccine at this time, however, I may readdress this issue with my provider at any time, or I may change my mind and accept the vaccine in the future
- *Accepted:* I am requesting that the vaccine be administered to me or the person named above

I understand the measures discussed and information provided to minimize risk during travel.

Patient/Parent/ or Guarantor Signature: _____ Date: _____
Printed Patient/Parent/or Guarantor Name: _____
Physician/Providers Signature: _____ Date: _____