Azusa Pacific University
Health Center
Travel Immunization

PATIENT INFORMATION / CONSENT

NAME: _____
Last First Middle Initial
ADDRESS: _____
Street City State Zip
BIRTHDATE: _____/____/_____AGE:_____ SEX: Male Female
Month Date Year
HOME PHONE#:_____CELLPHONE:_____
Email: _____

Where are you going? (Please List Countries in Order)
Approximate Length of Stay in Each Country
_____
_____
Departure Date_____Return Date: _____
Any chronic physical or mental illnesses (anxiety, seizures or depression)? _____
_____
Do you have eczema or other chronic dermatitis? yes no
If yes, what type? _____
No known allergies to medications. Medication allergy to: _____
_____
Allergic to eggs, feathers, yeast, mercury, quinine, formaldehyde, latex or insect/bee stings?
_____
Motion Sickness? yes no If yes, what have you used in the past? _____
Do you have high blood pressure? yes no If yes, are you on medication? _____
_____
Are you receiving steroid medications such as cortisone or prednisone? yes no
If yes, type _____
Are you receiving radiation or other treatments? yes no If yes, type _____
Are you pregnant now or is there a possibility that you might be pregnant? yes no
If yes, months _____
Have you had an allergic reaction to an immunization in the past? yes no If yes, what?
_____

The above information is accurate to my best recollection. I understand that insurance may not cover travel immunization services and I am responsible for all fees associated with this visit. Payment is due at the time of service by check, cash or putting on student account. I understand I will receive documentation of all vaccines received and am responsible for keeping the record in a safe place and up-to-date. Medications are not returnable per State Law.

Traveler/Parent/Guardian
Signature:_____
DATE:_____