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 filling 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 ______________________
First Name ______________________
Middle Name ______________________
Address ______________________
______________ APT # ________
City ______________________
Zip Code ________ State ________

Date of Birth ___/___/___
Gender **FEMALE / MALE / TRANS**
Email ______________________
How did you hear about us? ______________________

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 ______________________
First Name ______________________
Address (if different than child's) ______________________
____
Employed by ______________________
DOB ____________ SSN ____________

Relationship to child ____________
Legal guardian? **YES / NO**
Email ______________________
Phone number *(if different from above)* ____________
Full-Time Student? **YES / NO**
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? *$40/person or $60/group*	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 and understand that the CDC recommends the listed vaccines for my destination. I have received a copy of the CDC recommendations and received Vaccine Inventory Statements (VIS) for the vaccines I have chosen. **(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 ______________________________