Fairfield Department of Health
Immunization Clinic

ADULT TRAVEL PATIENT REGISTRATION

Patient Information			
First Name	Last Name	MI	Date of Birth
Address	City	State	Zip
Please check Primary phone	Home Phone ☐	Work Phone ☐	Cell Phone ☐
Other Name(s) Used		E-mail Address	
Gender ☐ M ☐ F	SSN	Preferred Language	Driver's License
Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Life Partner	Preferred Contact ☐ Mail ☐ Home Phone ☐ Day Phone ☐ Cell Phone ☐ Patient Portal (MyChart)	Ethnicity ☐ Cambodian ☐ Filipino ☐ Hispanic/Latino ☐ Non-Hispanic	Race ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other
Primary Care Provider		Referring Provider	

Please note that the Fairfield Department of Health will use the Social Security number and will upload any historical immunizations provided to our clinic or administered at our clinic into the state wide immunization data base used for immunization records.

May we leave a message on your home phone & cell phone or alternate phone? Yes________No________

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Immunization Record Release Authorization:

I authorize the Fairfield Department of Health to release Immunization Records via mail, fax, or email to *(check all that apply)*:
☐ Physicians ☐ Schools/Preschools ☐ Daycare Facilities ☐ Other ______________________

____ _____________

Signature of Patient or Responsible Party **Date**

Signature will be kept on file for one (1) year from above date. Authorization must be renewed after the one year has pa

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Acknowledgment of Receipt of Notice of Privacy Practices:

I acknowledge that I have reviewed a copy of the Notice of Privacy Practices provided to me by the Fairfield Department of Health. I understand that this Notice explains what the Fairfield Department of Health does to protect the use or disclosure of my health care information. I understand that I may request a copy of this Notice to be given to me and will refer to it if I have questions. I also understand that I should call the Health Department at (740) 652-2800 if I have questions or concerns about my privacy rights.

________ **(Initial)**

Financial Consent/Insurance Information:

We do not accept any Private Insurance at this time for the Travel Clinic. We can provide a receipt of Immunizations given to submit to you for your Insurance Carrier upon request.

Travel Clinic Operates with: Cash, Check, Discover, Visa or Master Card only.

Please initial by each statement:

_____I authorize the Fairfield Department of Health to release pertinent information to my insurance company when requested, or to facilitate payment of a claim.

_____I authorize the Fairfield Department of Health to apply for benefits on my behalf for covered services rendered by the patient and for payment to be made payable to the Fairfield Department of Health.

_____I agree to bring the most current copy of my insurance card with me to each visit and will pay all applicable co-pays or deductibles on the same day I receive medical services.

_____I agree with the consent and the provisions of medical treatment and the financial policy.

_____. _____

Signature of Patient or Responsible Party **Date**

Signature will be kept on file for one (1) year from above date. Authorization must be renewed after the one year has passed.

Consent for Services:

I, _____ (patient/guardian), do hereby give permission to the Fairfield Department of Health to perform the following services: **Travel Immunizations**.

Please initial by each statement:

_____I understand that this service is an elective service.

_____I understand that the Fairfield Department of Health does not bill Medicare, Medicaid or private insurances for this service.

_____I understand that I must pay the full amount of the charges.

_____I have read above and have had the opportunity to discuss this matter and my questions with the Health Department staff. My signature indicates that I agree to pay all charges.

_____. _____

Signature of Patient or Responsible Party **Date**

Signature will be kept on file for one (1) year from above date. Authorization must be renewed after the one year has passed.

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME _____

DATE OF BIRTH ____ / ____ / ____
month day year

For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	yes	no	don't know
1. Are you sick today?	☐	☐	☐
2. Do you have allergies to medications, food, a vaccine component, or latex?	☐	☐	☐
3. Have you ever had a serious reaction after receiving a vaccination?	☐	☐	☐
4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder?	☐	☐	☐
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☐	☐
6. In the past 3 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?	☐	☐	☐
7. Have you had a seizure or a brain or other nervous system problem?	☐	☐	☐
8. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐	☐
9. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☐	☐
10. Have you received any vaccinations in the past 4 weeks?	☐	☐	☐

FORM COMPLETED BY _____ DATE _____

FORM REVIEWED BY _____ DATE _____

Did you bring your immunization record card with you? **yes** ☐ **no** ☐

It is important for you to have a personal record of your vaccinations. If you don't have a personal record, ask your healthcare provider to give you one. Keep this record in a safe place and bring it with you every time you seek medical care. Make sure your health care provider records all your vaccinations on it.

immunization action coalition
IAC
immunize.org

Technical content reviewed by the Centers for Disease Control and Prevention

Saint Paul, Minnesota • 651-647-9009 • www.immunize.org • www.vaccineinformation.org

www.immunize.org/catg.d/p4065.pdf • Item #P4065 (2/16)

Information for Healthcare Professionals about the Screening Checklist for Contraindications to Vaccines for Adults

Are you interested in knowing why we included a certain question on the screening checklist? If so, read the information below. If you want to find out even more, consult the references listed at the end.

1. Are you sick today? *[all vaccines]*

There is no evidence that acute illness reduces vaccine efficacy or increases vaccine adverse events (1). However, as a precaution with moderate or severe acute illness, all vaccines should be delayed until the illness has improved. Mild illnesses (such as upper respiratory infections or diarrhea) are NOT contraindications to vaccination. Do not withhold vaccination if a person is taking antibiotics.

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2. Do you have allergies to medications, food, a vaccine component, or latex? *[all vaccines]*

An anaphylactic reaction to latex is a contraindication to vaccines that contain latex as a component or as part of the packaging (e.g., vial stoppers, prefilled syringe plungers, prefilled syringe caps). If a person has anaphylaxis after eating gelatin, do not administer vaccines containing gelatin. A local reaction to a prior vaccine dose or vaccine component, including latex, is not a contraindication to a subsequent dose or vaccine containing that component. For information on vaccines supplied in vials or syringes containing latex, see reference 2; for an extensive list of vaccine components, see reference 3.

An egg-free recombinant influenza vaccine (RIV3) may be used in people age 18 years and older with egg allergy of any severity who have no other contraindications. People younger than age 18 years who have experienced a serious systemic or anaphylactic reaction (e.g., hives, swelling of the lips or tongue, acute respiratory distress, or collapse) after eating eggs can usually be vaccinated with inactivated influenza vaccine (IIV); consult ACIP recommendations (see reference 4).

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3. Have you ever had a serious reaction after receiving a vaccination? *[all vaccines]*

History of anaphylactic reaction (see question 2) to a previous dose of vaccine or vaccine component is a contraindication for subsequent doses (1). Under normal circumstances, vaccines are deferred when a precaution is present. However, situations may arise when the benefit outweighs the risk (e.g., during a community pertussis outbreak).

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4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder? *[LAIV]*

The safety of intranasal live attenuated influenza vaccine (LAIV) in people with these conditions has not been established. These conditions, including asthma in adults, should be considered precautions for the use of LAIV.

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5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem? *[LAIV, MMR, VAR, ZOS]*

Live virus vaccines (e.g., LAIV, measles-mumps-rubella [MMR], varicella [VAR], zoster [ZOS]) are usually contraindicated in immunocompromised people. However, there are exceptions. For example, MMR vaccine is recommended and varicella vaccine should be considered for adults with CD4+ T-lymphocyte counts of greater than or equal to 200 cells/μL. Immunosuppressed people should not receive LAIV. For details, consult the ACIP recommendations (4, 5, 6).

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6. In the past 3 months, have you taken medications that affect your immune system, such as cortisone, prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments? *[LAIV, MMR, VAR, ZOS]*

Live virus vaccines (e.g., LAIV, MMR, VAR, ZOS) should be postponed until after chemotherapy or long-term high-dose steroid therapy has ended. For details and length of time to postpone, consult the ACIP statement (1, 5). Some immune mediator and immune modulator drugs (especially the antitumor-necrosis factor agents adalimumab, infliximab, and etanercept) may be immunosuppressive. The use of live vaccines should be avoided in persons taking these drugs (*MMWR* 2011;60 [RR2]:23). To find specific vaccination schedules for stem cell transplant (bone marrow transplant) patients, see reference 7. LAIV can be given only to healthy non-pregnant people ages 2 through 49 years.

7. Have you had a seizure or a brain or other nervous system problem? *[influenza, Td/Tdap]*

Tdap is contraindicated in people who have a history of encephalopathy within 7 days following DTP/DTaP given before age 7 years. An unstable progressive neurologic problem is a precaution to the use of Tdap. For people with stable neurologic disorders (including seizures) unrelated to vaccination, or for people with a family history of seizure, vaccinate as usual. A history of Guillain-Barré syndrome (GBS) is a consideration with the following: 1) Td/Tdap: if GBS has occurred within 6 weeks of a tetanus-containing vaccine and decision is made to continue vaccination, give Tdap instead of Td if no history of prior Tdap; 2) Influenza vaccine (IIV/LAIV): if GBS has occurred within 6 weeks of a prior influenza vaccine, vaccinate with IIV if at increased risk for severe influenza complications.

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8. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? *[LAIV, MMR, VAR, ZOS]*

Certain live virus vaccines (e.g., LAIV, MMR, VAR, ZOS) may need to be deferred, depending on several variables. Consult the most current ACIP recommendations for current information on intervals between antiviral drugs, immune globulin or blood product administration and live virus vaccines. (1)

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9. For women: Are you pregnant or is there a chance you could become pregnant during the next month? *[MMR, LAIV, VAR, ZOS]*

Live virus vaccines (e.g., MMR, VAR, ZOS, LAIV) are contraindicated one month before and during pregnancy because of the theoretical risk of virus transmission to the fetus. Sexually active women in their childbearing years who receive live virus vaccines should be instructed to practice careful contraception for one month following receipt of the vaccine. On theoretical grounds, inactivated poliovirus vaccine should not be given during pregnancy; however, it may be given if risk of exposure is imminent and immediate protection is needed (e.g., travel to endemic areas). Inactivated influenza vaccine and Tdap are both recommended during pregnancy. Both vaccines may be given at any time during pregnancy but the preferred time for Tdap administration is at 27–36 weeks' gestation. (1, 4, 5, 6, 8, 9)

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10. Have you received any vaccinations in the past 4 weeks? *[LAIV, MMR, VAR, yellow fever]*

People who were given either LAIV or an injectable live virus vaccine (e.g., MMR, VAR, ZOS, yellow fever) should wait 28 days before receiving another vaccination of this type. Inactivated vaccines may be given at any spacing interval if they are not administered simultaneously.

REFERENCES

1. CDC. General recommendations on immunization, at www.cdc.gov/mmwr/pdf/rr/rr6002.pdf.
2. Latex in Vaccine Packaging: www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/latex-table.pdf
3. Table of Vaccine Components: www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/excipient-table-2.pdf.
4. CDC. Prevention and control of influenza with vaccines: Recommendations of the Advisory Committee on Immunization Practices (ACIP), United States, 2015–16 Influenza Season at www.cdc.gov/mmwr/pdf/wk/mm6430.pdf, pages 818–825.
5. CDC. Measles, mumps, and rubella – vaccine use and strategies for elimination of measles, rubella, and congenital rubella syndrome and control of mumps. *MMWR* 1998; 47 (RR-8).
6. CDC. Prevention of varicella: Recommendations of the Advisory Committee on Immunization Practices. *MMWR* 2007; 56 (RR-4).
7. Tomblyn M, Einsele H, et al. Guidelines for preventing infectious complications among hematopoietic stem cell transplant recipients: a global perspective. *Biol Blood Marrow Transplant* 15:1143–1238; 2009 at www.cdc.gov/vaccines/pubs/hemato-cell-transplts.htm.
8. CDC. Notice to readers: Revised ACIP recommendation for avoiding pregnancy after receiving a rubella-containing vaccine. *MMWR* 2001; 50 (49).
9. CDC. Updated recommendations for use of tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis vaccine (Tdap) in pregnant women: Recommendations of the ACIP. *MMWR* 2012; 62 (7):131–4.

Fairfield Department of Health
Travel Immunizations
Standing Orders

Name_____Date of Birth_____.

Address_____City_____State____Zip _____.

1. Where traveling?_____.
2. When leaving and length of stay?_____.
3. Allergies?_____.
4. Previous Immunizations?_____.
5. Are you currently Immunocompromised? Yes_____No_____.
6. Are you pregnant? Yes_____No_____.

DO NOT WRITE BELOW LINE (NURSES ONLY)

_____

Vaccines given:

A. Yellow Fever for Africa and South America, Epidemic areas of Panama, mosquito born.
   - Certificate for travel valid 10 days after receiving vaccine
   - One dose lasts 10 years, 0.5 ml sub q
   - Live virus vaccine
   - Contraindications to receiving vaccine: less than 9 months of age, severe egg allergy, immunocompromised, thymus condition

   Yellow Fever vaccine given? Yes_____No_____.

B. Typhoid for India, developing areas of Asia, Eastern Europe, South Asia (India), South America, South Pacific, Middle East, Africa, Central and Latin America.
   - Transmitted fecal-oral route
   - One dose 0.5 ml IM, then boost every 2 years
   - Contraindications to receiving vaccine: less than 2 years old
   - Precaution: pregnancy, <u>OB documentation required to administer</u>

   Typhoid vaccine given? Yes_____No_____.

C. Poliomyelitis for south Asia, Africa, and Indian Subcontinent, Middle East
   - Transmitted fecal-oral route
   - Indicated for adults over 18 who have not gotten a dose since childhood
   - One time dose IPV, 0.5 ml IM or Sub Q

   Polio vaccine given? Yes_____No_____.

D. Tetanus/Diphtheria vaccine
- Need booster every 10 years, 0.5 ml IM

Td vaccine given? Yes_____No_____.

E. Hepatitis A recommended for travelers going anywhere outside the USA
- Transmitted fecal-oral route
- 1.0 ml IM, one booster dose 6-12 months later
- Contraindications: less than 2 years old

Hepatitis A vaccine given? Yes_____No_____.
Twinrix given (Hep A/Hep B combo)? Yes_____No_____.

F. MMR vaccine recommended for travelers going outside the USA
- If Yellow Fever vaccine is needed and MMR is not given then a 28 day period must be observed
- Contraindicated if pregnant or allergic to neomycin or gelatin or past reaction
- Contraindicated if immunosuppressed
- Contraindicated if previous vaccine or if had disease
- 0.5 ml Sub Q

MMR vaccine given? Yes_____No_____.

G. Meningitis Vaccine required for entry into Saudi Arabia, and if visiting epidemic area during December to June (Africa).
- Proof of vaccine for Saudi Arabia issued not more than 3 years and not less than 10 days before arrival in Saudi Arabia
- Contraindicated if allergic reaction
- Given IM or Sub Q, depending on vaccine type

Meningitis vaccine given? Yes_____No_____.

H. Malaria for Central and South America, some parts of the Caribbean, Africa, India, Southeast Asia, Middle East, and islands of the South Pacific
- Mosquito born

NOTE: None of these will be prescribed for longer than 11 weeks due to necessity of follow up testing on kidney and liver function after that time.

Mefloquine (Lariam):250 mg – take one tablet one week before reaching endemic area, then take one tablet once a week on the same day of the week while traveling. Continue taking one tablet once a week for 4 weeks after leaving area.
- Dosage for children: 15-19 kg – ¼ tablet, 20-30 kg – ½ tablet, 31-54 kg – ¾ tablet, >45 – 1 tablet
- Contraindicated if history of severe depression or major psychotic disorder, history of seizures (excluding febrile)

Mefloquine called in to pharmacy? Yes___Where_____.

Chloroquine (Aralen): 500 mg – once a week for travel to areas with chloroquine-sensitive malaria.

- Contraindicated if allergic to quinines

Chloroquine called in to pharmacy? Yes___Where_____.

Doxycycline: 100 mg – begin taking 1-2 days before reaching endemic area, then continue taking one a day during travel time, and continue taking one a day for 4 weeks after leaving the area.

- Contraindicated if pregnant, < 8 years old, allergic to Doxy or tetracycline

Doxy called in to pharmacy? Yes___Where_____.

Malarone (250mg atovaquone/100mg proguanil) – Adult dose: 1 tablet daily. Begin taking 1-2 days before travel, continue once a day while traveling and for 7 days after leaving area. Pediatric dose (tablet=62.5mg/25mg) 11-20 kg – 1 tab daily, 21-30 kg – 2 tabs daily, 31-40 kg – 3 tabs daily, >40 kg – adult dose.

- Contraindicated if severe renal impairment, pregnant, breast feeding, or children <11 kg.

Malarone called in to pharmacy? Yes___Where_____.

I. TYPHOID VACCINE LIVE, ORAL Ty21a

- Vivotif (Initial dose) (Dispense 4 no refills)Take 1 capsule by mouth on day 1, followed by subsequent doses on day 3,5,7. (Alternate day schedule) with cold or luke-warm water on an empty stomach (one hour before meals or two hours after meals). Do not crush or chew capsules and they must be stored in the refrigerator at all times. Separation of up to 48 hours between doses is acceptable but all doses should be completed over 10 days. If >48 hours since last dose contact the manufacturer for additional guidance. For optimal protection the vaccine series should be completed at least 1 week prior to potential exposure.

  Vivotif called into pharmacy? Yes___ Where_____.

7. Current destination site recommendations reviewed on Internet at www.ccic.gov (nurse initials).

Nurse's Signature_____Date_____.

Physician's Signature_____Date_____.