Peachtree Travel Clinic **Client Completes Part 1**

Vaccination Request Form

PART 1

NAME:		DATE OF CLINC VISIT:
DATE OF BIRTH:	AGE:	LAST FOUR OF SSN:
PRIMARY PHYSICIAN:		HOME TELEPHONE:
HOME ADDRESS:		WORK TELEPHONE:
		EMAIL ADDRESS:

Medical History		Are you allergic to eggs or egg products?	No Yes ☐ ☐
Allergies		Are you pregnant?	☐ ☐
Medications			

VACCINATIONS REQUESTED	REASON

All professional services rendered are charged to the client with the exception of corporate accounts with prior payment arrangements. Many insurance companies do no cover vaccinations. We therefore require payment at the time of service. You will receive a copy of your bill that you can submit to your insurance company for proper reimbursement.
I have read and agree to the above conditions:

_____ _____
Client Signature **Date**

PART 2

IMMUNIZATION RECOMMENDATIONS	
Immunization	O A D V[1]
Tetanus/Diphtheria (Td/Tdap)	☐ ☐ ☐ ☐
Polio	☐ ☐ ☐ ☐
Typhoid (oral/ Vi)	☐ ☐ ☐ ☐
Hepatitis A	☐ ☐ ☐ ☐
Hepatitis B	☐ ☐ ☐ ☐
Twinrix	☐ ☐ ☐ ☐
Yellow Fever	☐ ☐ ☐ ☐
Meningococcal (Menomune/ Menactra)	☐ ☐ ☐ ☐
Japanese Encephalitis	☐ ☐ ☐ ☐
Measles/Mumps/Rubella	☐ ☐ ☐ ☐
Varicella	☐ ☐ ☐ ☐
Zostavax	☐ ☐ ☐ ☐
Gardisil	☐ ☐ ☐ ☐
	☐ ☐ ☐ ☐
	☐ ☐ ☐ ☐

[1]O= Offered to client; A=Accepted by client; D=Declined by client; V= Vaccine information sheet given to client

_____ _____
Nurse/ Physician Signature Date