



Discover Island Drug

Your local full service pharmacy,
wellness, gift, and much More store!

Travel Medicine Form

Welcome to Island Drug! Please complete this form so that we can ensure that our pharmacy file is accurate and up to date. Thanks!

_____/_____/_____
 First Name M.I. Last Name M or F Date of Birth (MM/DD/YYYY)

 Street Address (PO Box acceptable if given with physical address) City

 State Zip Code (_____) Home Phone Email Address

Travel Plans:

 Country of Destination Departure Date Length of Stay

ALLERGIES: No Known Allergies Eggs Bovine products Neomycin Yeast Thimerosal Gelatin
 Erythromycin Amphotericin B Polymyxin B Streptomycin Other: _____

MEDICAL CONDITIONS: No Known Conditions High Blood Pressure Diabetes (Type I) Diabetes (Type II)
 High Cholesterol Asthma Arthritis Depression Pregnancy (Due: _____)
 Other: _____

Primary Care Doctor or Clinic: _____

The Following will be completed with your Island Drug pharmacist

VACCINATION	CDC RECOMMENDATION (based on destination)	Traveler's (or designee's) Consent	VACCINATION	CDC RECOMMENDATION (based on destination)	Traveler's (or designee's) Consent
Hepatitis A			Hepatitis B		
Yellow Fever			Rabies		
Typhoid			Polio		
Japanese Encephalitis			Meningitis		
Diphtheria/Tetanus					
Malaria Prevention					

I have received information sheets for the vaccinations and/or medications noted above, and have had explained to me the information on each sheet. I have had the chance to ask questions and they were answered to my satisfaction. I believe I understand the benefits/risk of each vaccine/medication and ask that it is given to me or the person named above for whom I am authorized to make this request. I also received the Notice of Privacy Practices.

 Signature

 Date (MM/DD/YYYY)

Office use only:**Patient: (middle PT sticker)**

Signature of Administrator:

Hepatitis A (1) -2 nd Dose (6 months)	DATE: _____ SITE: R OR L Deltoid Thigh	MNF: _____ LOT# _____ EXP DATE: _____	
	DATE: _____ SITE: R OR L Deltoid Thigh	MNF: _____ LOT# _____ EXP DATE: _____	
Hepatitis B (1) -2 nd Dose (1 month) -3 rd Dose (6 months)	DATE: _____ SITE: R OR L Deltoid Thigh	MNF: _____ LOT# _____ EXP DATE: _____	
	DATE: _____ SITE: R OR L Deltoid Thigh	MNF: _____ LOT# _____ EXP DATE: _____	
	DATE: _____ SITE: R OR L Deltoid Thigh	MNF: _____ LOT# _____ EXP DATE: _____	
Yellow Fever (every 10 years)	DATE: _____ SITE: R OR L Deltoid Thigh	MNF: _____ LOT# _____ EXP DATE: _____	
Rabies (1) (pre-exposure) -2 nd Dose (7 days) -3 rd Dose (21 or 28 days)	DATE: _____ SITE: R OR L Deltoid Thigh	MNF: _____ LOT# _____ EXP DATE: _____	
	DATE: _____ SITE: R OR L Deltoid Thigh	MNF: _____ LOT# _____ EXP DATE: _____	
	DATE: _____ SITE: R OR L Deltoid Thigh	MNF: _____ LOT# _____ EXP DATE: _____	
Typhoid (every 2 years)	DATE: _____ SITE: R OR L Deltoid Thigh	MNF: _____ LOT# _____ EXP DATE: _____	
Polio	DATE: _____ SITE: R OR L Deltoid Thigh	MNF: _____ LOT# _____ EXP DATE: _____	
Japanese Encephalitis (1) (every 2 years?) -2 nd Dose (7 days) -3 rd Dose (30 days)	DATE: _____ SITE: R OR L Deltoid Thigh	MNF: _____ LOT# _____ EXP DATE: _____	
	DATE: _____ SITE: R OR L Deltoid Thigh	MNF: _____ LOT# _____ EXP DATE: _____	
	DATE: _____ SITE: R OR L Deltoid Thigh	MNF: _____ LOT# _____ EXP DATE: _____	
Meningitis	DATE: _____ SITE: R OR L Deltoid Thigh	MNF: _____ LOT# _____ EXP DATE: _____	
DTaP (every 10 years)	DATE: _____ SITE: R OR L Deltoid Thigh	MNF: _____ LOT# _____ EXP DATE: _____	