Desired Administration Date

Please select your store

32170 State Route 20
Oak Harbor, WA 98277
360.675.6688 P
360.675.1563 F
www.islanddrug.com
wecare@islanddrug.com

11042 State Route 525 #130
Clinton, WA 98236
360.341.3885 P
360.341.3886 F
www.islanddrug.com
wecare.south@islanddrug.com

Travel Medicine Form

Welcome to Island Drug! Please complete this form so we can ensure our pharmacy 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** ☐Penicillin ☐Sulfa ☐Neomycin ☐Gelatin ☐Other:_____
MEDICAL CONDITIONS: ☐No Known Medical Conditions ☐High Blood Pressure ☐Diabetes (Type I) ☐Diabetes (Type II) ☐High Cholesterol ☐Asthma ☐Arthritis ☐Depression ☐Pregnancy (Due: _____) ☐Other:_____
Did you receive a flu shot last year? ☐YES ☐ NO

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:
DATE OF VACCINATION:_____ Signature of Administrator:_____

MNF:_____LOT#_____EXP DATE:_____

SITE OF INJECTION: R OR L Deltoid

Visit us online at ***www.islanddrug.com***

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Office use only:

Patient: **(middle PT sticker)**

Signature of Administrator:

Hepatitis A (1)	DATE:_____ SITE: R OR L Deltoid Thigh	MNF:_____ LOT#_____ EXP DATE:_____	
-2nd Dose (6 months)	DATE:_____ SITE: R OR L Deltoid Thigh	MNF:_____ LOT#_____ EXP DATE:_____	
Hepatitis B (1)	DATE:_____ SITE: R OR L Deltoid Thigh	MNF:_____ LOT#_____ EXP DATE:_____	
-2nd Dose (1 month)	DATE:_____ SITE: R OR L Deltoid Thigh	MNF:_____ LOT#_____ EXP DATE:_____	
-3rd Dose (6 months)	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)	DATE:_____ SITE: R OR L Deltoid Thigh	MNF:_____ LOT#_____ EXP DATE:_____	
-2nd Dose (7 days)	DATE:_____ SITE: R OR L Deltoid Thigh	MNF:_____ LOT#_____ EXP DATE:_____	
-3rd Dose (21 or 28 days)	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	

Office use:
DATE OF VACCINATION:_____ Signature of Administrator:_____

MNF:_____LOT#_____EXP DATE:_____

SITE OF INJECTION: R OR L Deltoid

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		DATE:_____	
Polio	DATE:_____ SITE: R OR L Deltoid Thigh	MNF:_____ LOT#_____ EXP DATE:_____	
Japanese Encephalitis (1) (every 2 years?)	DATE:_____ SITE: R OR L Deltoid Thigh	MNF:_____ LOT#_____ EXP DATE:_____	
-2nd Dose (7 days)	DATE:_____ SITE: R OR L Deltoid Thigh	MNF:_____ LOT#_____ EXP DATE:_____	
-3rd Dose (30 days)	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:_____	

Signature:

Email:

Office use:
DATE OF VACCINATION:_____ Signature of Administrator:_____

MNF:_____LOT#_____EXP DATE:_____

SITE OF INJECTION: R OR L Deltoid