Wheeling-Ohio County Health Department
City County Bldg., Rm. 106
1500 Chapline Street
Wheeling, WV 26003
Main Phone: (304) 234-3682 Fax: (304) 234-6405 Cell: (304) 830-0420
Website: www.ohiocountyhealth.com

Travel Vaccination Clinic

Today's Date____________________

Name ____ Date of Birth____________________

Address _____________________________________ Email__________________________

_____________________________________ Insurance Provider______________

Phone: Best # to reach you_________________________ Alternative #____________________

Primary Care Provider _____________________________ Phone__________________________

Please bring photo ID to your appointment.

Travel Plans/Itinerary

Date of Departure __________________________________ Duration of Trip________________

Destination Country	Cities & airport of destination	Departure Date	Duration of Visit	Purpose	Rural Sites (Y/N)
1.					
2.					
3.					
4.					

Medical Information

In order to provide your travel immunizations as safely as possible we need to know the following about you health status:

	Yes	No	Don't Know
Have you ever had a positive TB test?			
Allergic to any food or medications? **Explain:**			
Allergic to latex?			
Have you ever had a reactions/side effect from a vaccination?			
Are you pregnant or nursing?			
Are you currently under the care of a physician for a medical condition?			

List all medications you are currently taking, either prescription or over the counter:

Travel Activity

Please indicate your travel activity.

Activity	Yes	No	Don't Know	Explain
Outdoors				
Delivering health care.				
Using local health care (surgery, acupuncture, etc.).				
Cave exploration (spelunking).				
Travel to over 9,000 feet.				
Close exposure to animals or veterinary care.				
Other:	**Explain:**			

Have you traveled out of the country in the past? Y/N Explain:________________________

Immunization Information

Please indicate the date of vaccinations and/or the date of illness for the following (***please bring or include your most current immunization record to your appointment***):

Immunization	Had Vaccine (Y/N)	Date	Had Disease (Y/N)	Date
Hepatitis A				
Hepatitis B				
Typhoid				
Yellow Fever				
Meningococcal				
Polio				
Tetanus/Diphtheria (Td)				
Tetanus/Diphtheria/Pertussis (Tdap)				
Measles Mumps Rubella (MMR)				
Influenza				
Japanese Encephalitis				
Other				
Cholera				
Rabies				

Have you had any immunizations in the last 4 weeks? ____________________________________

*FOR HEALTH DEPARTMENT USE

Health Department Travel Vaccines

Vaccine	Required	Recommended	Received
Hepatitis A			
Hepatitis B			
Typhoid Vaccine Typhoid Oral			
Yellow Fever			
Meningococcal			
Polio			
Tetanus/Diphtheria (Td)			
Tetanus/Diphtheria/Pertussis (Tdap)			
Measles Mumps Rubella (MMR)			
Influenza			
Japanese Encephalitis			
Cholera (Oral)			
Malaria (prescription only)			
Other			

Appointment Schedule ________________________________ Date client notified________________

Financial

Type of Vaccine/Med.	Vaccine Ordered	Vaccine Received	Cost (per vaccine)	Paid (Y/N)
Hepatitis A				
Hepatitis B				
Typhoid				
Yellow Fever				
Meningococcal				
Polio				
Tetanus/Diphtheria (Td)				
Tetanus/Diphtheria/Pertussis (Tdap)				
Measles Mumps Rubella (MMR)				
Influenza				
Japanese Encephalitis				
Cholera				
Other:				
Admin Fee				
Total				