

Please fill in sections A, B, C, and D as completely as possible

CD: _____

A. Personal Information							
Last Name:			First Name:			MI:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Address:			City:			<input type="checkbox"/> non-binary <input type="checkbox"/> other:	
Postal Code:		Email:			Cdn Citizen : yes <input type="checkbox"/> no <input type="checkbox"/>		
Home Tel:		Work Tel:		Cell		Children Only	
Birth Date: D M Y		Age:	Carecard:		Weight:	Consent Obtained <input type="checkbox"/>	
Emergency Contact:			Phone:		Consent By: Mother <input type="checkbox"/> Father <input type="checkbox"/>		
Family Doctor:			Phone:		Guardian Name:		

B. Travel Itinerary								
Date of Departure: D M Y				Purpose of trip: Vacation- tour, adventure, cruise Work, Service Other:				
Area of Travel				Food and Accommodation				Comment
Country	Duration	Urban (Cities)	Rural (Country Side)	Business 1 st Class	Tourist Package	Backpack Low Budget	Home Stay Friends Relatives	

C. Medical History				D. Immunization History			
Do any of the following apply to you?			Yes	No	What vaccines have you had?		Date
Fainted from having an injection					Tetanus/Diphtheria		
Severe reaction to immunization					Pertussis (Whooping Cough)		
Fever in the past 24 hours					Polio		
Current or planned pregnancies/Breastfeeding					Measles / Mumps / Rubella		
Immune suppression (eg. HIV, cancer, leukemia, organ transplant, steroid medication)					Chickenpox (disease / vaccine)		
History of Guillain-Barré Syndrome					Shingles (vaccine / disease)		
Received blood products in past year					Flu / Prevnar13 / Pneumococcal 23		
Bleeding disorders					Dukoral		
Thymus disorders (Myasthenia Gravis)					Typhoid		
G6PD deficiency					Hepatitis A		
Disorders of the spleen / liver / kidney					Hepatitis B		
Bowel conditions: Irritable bowel syndrome/Crohn's/Colitis					Meningitis		
Depression, anxiety, psychosis					Yellow Fever		
Previous seizures/epilepsy/neurological conditions					Japanese B Encephalitis		
Heart disease/Diabetes					Rabies		
Other (Note, it is important to list ALL diseases and conditions that you have):					Other:		

Allergies (including: Eggs, Bee Stings, Medications, Yeast, Gelatin, Latex):

Current Medical Conditions	Current Medications including prescription, herbal, over the counter, birth control pills
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