SPRUCE MULTISPECIALTY GROUP
1275 East Spruce, Suite 101
Fresno. California 93720
(559) 439-5757

Simple Immunizations

Name _____ Date of Birth: _____
(If minor, name of parent/guardian) _____
Age _____ Gender: M/F
Primary Physician _____

Allergies to medications, vaccinations, foods or environmental factors

_____
_____

Current medical conditions (such as asthma, high blood pressure, etc.)

_____
_____
_____

Current medications/hormones

_____
_____

Do you have any of the following conditions? (Please check yes or no, ADD OTHERS NOT LISTED)

	Y	N		Y	N		Y	N		Y	N
Pregnancy			HIV disease			Heart disease			Psychiatric disorders		
Dental disease			Over 60			Diabetes			Seizures/epilepsy		
Depression			Blood Conditions			Lung disease			Heart rhythm problems		
Cancer			Psoriasis						Long term steroid use		
Other:											

Are you planning on becoming pregnant in the next three months? Yes/no

Prior immunizations (with dates): Attach immunization card if available.

	Date		Date		Date
Diphtheria/tetanus/pertussis		Rabies		Plague	
Influenza		Immune globulin		Lyme's Disease	
Polio		Japanese encephalitis		BCG (TB)	
Hepatitis A		Typhoid oral			
Hepatitis B		Typhoid injection			
Measles		Yellow fever			
Mumps		Cholera			
Rubella		Menomune			
Pneumoccocal		Menactra			

Patient Acknowledgement
I am satisfied that relevant VAERS informational handouts on the vaccines that I am receiving were given to me. My questions about the diseases and vaccines have been answered to my satisfaction. I believe I understand the benefits and risks of each vaccine I am to receive and authorize Fresno International Travel Medical Center (FITMC) staff to administer these vaccines. I know it is my responsibility to contact FITMC with any adverse reaction to vaccinations/prescriptions received from FITMC.

Signature of person to receive vaccine or parent or guardian:

---------- _____
Signature Date

Documentation

Date	MA	Date	Provider	notes

#1 Review vaccine status	Reg day	Acc day	Comp Before Travel day	#2Date series Comp	#3 Had Disease	#4 We recommend V=vaccine S=serology	#5 VAERS Pt initial/ date	#6 Date vaccine given initials	#7 Site	#8 Manufacturer Lot/date	#9 Next dose due
Td											
Adacel											
Meningococcal											
Polio											
Varicella #1	0										
Varicella #2	30-60										
Influenza											
Pneumococcus											
Zostavax											
MMR #1											
MMR #2											
Hep A#1	0		14								
Hep A#2	180										
Hep B#1	0	0									
Hep B #2	30	7									
Hep B#3	180	21									
Twinrix#1	0	0									
Twinrix#2	30	7									
Twinrix#3	180	21									

* Site: LD-left deltoid LT-left thigh RD- right deltoid RT-right thigh SQRA-subq right arm SQLA- subq left arm

#10 Patient Acknowledgement

I am satisfied that relevant VAERS informational handouts on the vaccines that I am receiving were given to me. My questions about the diseases and vaccines have been answered to my satisfaction. I believe I understand the benefits and risks of each vaccine I am to receive and authorize Fresno International Travel Medical Center (FITMC) staff to administer these vaccines. I know it is my responsibility to contact FITMC with any adverse reaction to vaccinations/prescriptions received from FITMC.

Signature of person to receive vaccine or parent or guardian

_____ _____ _____ _____

signature date witness date