LIVINGSTONE STREET CLINIC
9 LIVINGSTONE ST IVANHOE, VIC , 3079
Ph: 9497 1188

TRAVEL HEALTH

Please ensure all relevant information is provided. Your Doctor shall not be liable for any advise or treatment provided based on incorrect or incomplete information.

PERSONAL DETAILS

Name:		
Address:		
DOB:	**Gender:**	**Occupation:**
Phone number:	**Mobile:**	
Next of Kin:		
Medical History: (CIRCLE) DIABETES ASTHMA EPILEPSY ANXIETY DEPRESSION MASTECTOMY HEP A/ B SPLENECTOMY BLOOD TRANSFUSION IMMUNE DISORDERS **OTHERS:**		
Current medications:		
Any Allergies:		
If female: Are you pregnant now? **Are you breast feeding?** **Do you plan to be pregnant while travelling?**		

TRAVEL HISTORY

Are you well today?	YES NO
Have you travelled to Asia or South America before? If so…did you experience any health problems during this period of stay?	YES NO YES NO
Have you been a patient in Hospital in the last 6 weeks?	YES NO
Do you have a thymus disorder – including myasthenia gravis, thymoma, thymectomy and DiGeorge Syndrome?	YES NO
Do you have cancer, HIV positive, Hep A , Hep B or any other immune system problem?	YES NO
Have you had chemotherapy or radiotherapy for malignant disease within the last 6 months?	YES NO
Have you received a bone marrow transplant within the last 6 months?	YES NO
Are you undergoing drug induced immune-suppression?	YES NO
Have you received any other vaccines or treatment in the past 4 weeks?	YES NO
Have you felt faint or had a reaction following a vaccination or giving blood?	YES NO

TRAVEL PROFILE

Any previous vaccinations:

DATE	VACCINE	DATE	VACCINE	DATE	VACCINE

TRAVEL TYPE: (CIRCLE)
WORK FIVE STAR/RESORT BACKPACKING ADVENTURE RELAXATION

Departure date: **Total time away:** **Return date:**

	Country	Duration	Conditions RURAL - URBAN - BACKPACK – RESORT - TRANSIT
1			
2			
3			

Following page for yellow fever travellers only

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YELLOW FEVER VACCINATION

1. **Ask the nurse for the Yellow Fever information sheet**
2. **Read and complete form below**
3. **Following vaccination you are required to remain in the clinic for 30mins, report to nurse before leaving.**
4. **You will receive a 'yellow booklet' that certifies you have been immunised against Yellow Fever, you must take the booklet with you when travelling.**

PERSONS WHO SHOULD NOT HAVE THIS VACCINE :

- **YOU HAVE A HISTORY OF ALLERGY TO EGGS, CHICKEN OR GELATIN**
- **YOU ARE IMMUNO DEFICIENT DUE TO CHEMOTHERAPY, RADIATION THERAPY, ACTIVE HIV, TRANSPLANTATION OR ARE TAKING HIGH DOSES OF STEROIDS OR METHOTREXATE.**
- **YOUR THYMUS GLAND HAS BEEN REMOVED OR IF HAVE A THYMUS DISORDER**
- **PERSONS UNDER 9 MONTHS OF AGE**
- **YOU HAVE RECEIVED ANOTHER "LIVE" VACCINE IN THE LAST 28 DAYS (vaccination will have to be postponed)**
- **YOU AREA PREGNANT OR BREAST FEEDING**

YELLOW FEVER Vaccine Precaution - 60 years or older

- *If you are 60 or older, there is an increased risk of severe neurological and multi-organ failure complications compared to younger age groups. Risks and benefits of vaccination should be carefully weighed against the destination-specific risk of exposure*
- *Increased Risk :Consider signed MEDICAL WAIVER (see attachment for more detailed information)*

ADVERSE REACTIONS THAT MAY OCCUR

MILD LOCAL AND GENERAL reactions occur in 2-5% of people who receive the vaccine.

 LOCAL REACTIONS: TENDERNESS, REDNESS, SWELLING OR PAIN AT THE SITE OF INJECTION LASTING 1-5 DAYS AFTER VACCINATION
 GENERAL REACTIONS: LOW GRADE FEVER, WEAKNESS, MUSCLE ACHES AND HEADACHE, SEVERAL DAYS AFTER VACCINATION AND LASTING 5-10 DAYS
 VERY RARE REACTIONS: MUSCLE PAIN, ARTHRITIS, RASH, ABDONIMAL PAIN, GENERALIZED SWELLING AND ITCHING.

Serious reactions include the following symptoms:

 LIFE -THREATENING ALLERGIC REACTIONS FROM VACCINES ARE EXTREMELY RARE. IF THEY DO OCCUR, IT IS WITHIN A FEW MINUTES TO A FEW HOURS AFTER INJECTION. CALL 000 IF YOU HAVE ANY SIGNS OF A SERIOUS ALLERGIC REACTION WHICH CAN INCLUDE: DIFFICULTY BREATHING, FACIAL SWELLING HOARSENESS , WHEEZING, HIVES, PALLOR, WEAKNESS , RAPID HEART RATE, DIZZINESS.

 RISKS OF SIDE EFFCTS INCREASE WITH AGE ESPECIALLY IF OVER 60.

I HAVE READ THE ABOVE AND THE VACCINE INFORMATION STATEMENT SHEET AND UNDERSTAND THIS INFORMATION. I VOLUNTARILY CONSENT TO RECEIVE THE YELLOW FEVER VACCINE.

SIGNED:_____

DATE:_____

PRINT NAME:_____

If Child is under 18, fill out section below:

Guardian Name (Print): _____

Guardian signature:_____