

REQUEST FOR TRAVEL MEDICINE SERVICES

Patient Name:			_ Date of Birth:/_	/
Home Office: (check one)	[] Peabody [] Salem [] Lynn [] Melrose	[] Reading	
Home Address:		City:_	State:	Zip:
Home Phone:	Cell Phone:		Today's Date:	
Person completing form:		Relationship to Pa	tient:	

The risk for contracting diseases during travel—particularly when visiting family members or rural areas—can be significant and potentially life-threatening. Precautions can be taken to protect your child from contracting many of these diseases. Additional vaccinations or oral medications may even be recommended, depending on the destination.

In order to ensure your child's health and safety during travel abroad, the pediatricians and nurse practitioners at PHCA recommend discussing your travel plans with our staff at least **six weeks prior to your departure**. This will allow us to administer any required vaccinations well in advance of your trip. In addition, medications that may be required for travel may not routinely be stocked at your pharmacy, and are often administered as early as one week prior to your departure. Advance notice is therefore important. However, should you find yourself traveling last-minute, please contact our clinic so that we might provide your child with the best possible care.

To access our travel medicine services, please answer the following questions and return the completed form to the address listed below. (Please use a separate sheet for each person traveling.) Once we receive your request, you will be sent a packet with the proposed travel services, a consent form, and informational sheets on all recommended vaccines. Please send back your signed consent form as soon as possible so one of our staff can contact you to schedule your appointment.

<u>Destination(s)</u>		
Country:		
Please specify cities/regions:		
If visiting multiple countries, please include a co		
Departure date:	Return date:	
Will you be visiting rural areas during your stay?	□ Ye	es 🗆 No
Will you be working with animals?	\Box Ye	es 🗆 No
If so, in what way?		
If so, in what way? Will you be spending time in caves or sleeping outside?	\Box Y ϵ	es 🗆 No
Can you/your child swallow pills?	$\Box Y\epsilon$	es 🗆 No
Have you/your child received any vaccine outside our		
If so, which one(s)?		
Does your child have any chronic medical issues?		
D / 1:11.1		
Do you/your child have any drug allergies?		
Pharmacy of choice:		
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Return completed form to:

Pediatric Health Care Associates Attention: Triage - Travel Medicine 10 Centennial Drive Peabody, MA 01960 Fax: (978) 535-5910