Attn: **Glenda @ Summit Travel Medicine Clinic** *FAX: 615-* **846-4499**

RE: **LifeWay Trips**

SUMMIT TRAVEL MEDICINE CLINIC

Stephen K. Felts, M.D., FACP

TRAVELER ITINERARY AND MEDICAL HISTORY

Name ____________________________ Home Phone ________________ Work Phone ______________

Address ___________________________ City ______________________ State _______ ZIP _________

SS# ____________________ Birth date __________________ Age __________ Sex ☐ Male ☐ Female

Please complete the following information as best you can. It will help us determine what kind of disease protection and advice you will need.

YOUR TRAVEL PLANS

DEPARTURE DATE_________________________ RETURN DATE ____________________________

PLEASE LIST THE COUNTRIES YOU WILL VISIT IN SEQUENCE IF POSSIBLE

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Please check any of the following which may apply to your travel:
( ) scuba diving ( ) camping ( ) overnight stays in rural areas ( ) household or sexual contact with locals
( ) if your travel will involve other than routine business or vacation activities, please inform us of the details during your visit.

MEDICAL HISTORY

Drug Allergies ________________________________ Are you pregnant? ☐ Yes ☐ No

Current Medications: ____

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Check all that apply:

☐ heart disease ☐ lung, liver or kidney disease ☐ hypertension
☐ ulcer disease ☐ thimersol (a mercury derivative) allergy ☐ fainting after injections
☐ allergy to any vaccine ☐ measles history ☐ hepatitis history
☐ diabetes ☐ history of seizures ☐ egg allergy
☐ immunosuppression (chemotherapy, steroids, prednisone, radiation therapy, HIV infection)

Check all immunizations you have ever had and indicate approximate date of last dose if known:

☐ tetanus ______________________ ☐ diphtheria _____________ ☐ oral polio _______________
☐ injection for polio ______________ ☐ hepatitis A ____________ ☐ hepatitis B ________________
☐ typhoid oral __________________ ☐ typhoid injection ________ ☐ yellow fever _______________
☐ pneumonia ___________________ ☐ influenza ______________ ☐ measles or MMR ___________
☐ meningitis ____________________ ☐ Japanese encephalitis vaccine

THE ABOVE INFORMATION IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I CONSENT TO THE ADMINISTRATION OF INDICATED VACCINES TO MYSELF (OR TO THE PATIENT NAMED ABOVE FOR WHOM I AM THE PARENT OR GUARDIAN) AS AGREED BY DR. FELTS OR HIS STAFF.

_________________________________ _________________________________

SIGNATURE DATE

Name and Address of Primary Care Physician

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Consent for Services: I understand that, while remarkably safe, vaccines can, in rare instances, cause complications including death. I agree to accept this risk in order to decrease my chances of contracting a serious preventable disease.

I also understand that NTMS does not file claims for nor accept any form of insurance payment and does not have any contract with any insurance plan. (You will be provided with a record of our services and your payments which you may file to claim any reimbursement provided by your insurance plan.) I understand that my health insurance is a contract between me and my insurance company and does not involve NTMS. I understand that NTMS will not refund any difference between my insurance reimbursement and NTMS charges.

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Print Name

___________________________________ ______________________

Signature Date

Optional

Consent for NTMS to send a copy of my visit record to my personal physician, whose name and address appear below: ____

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Fax to Summit Clinic along with a copy (if you have one) of your International Certificate of Vaccination (PHS-731) -- (the yellow shot record)