NORTHERN BRITISH COLUMBIA TRAVEL HEALTH AND VACCINATION CLINIC (NBCTHVC)

925 Vancouver Street, Prince George, BC V2L 2P6 Phone: 250-277-1887, Fax: 250-563-8285

Please Bring To Your Appointment: Vaccination/Immunization Records (Childhood/Travel) & Travel Itinerary

Name: ______________________ **Date:** __________

Birth Date (DD/MM/YYYY) **:** (/ /)

Address: ______________________ **Postal Code:** __________

City: __________ **Province:** __________ **Cell:** __________

Phone: Home: __________ **Personal Health Number:** __________

Immunized as a child? ☐ Yes ☐ No ☐ Unsure **Family Doctor:**

Purpose of visit: ☐ Travel ☐ School ☐ Work: __________

If NOT for travel, please go to medical conditions.

Destination: __________ **Duration of Stay:** __________

Date of Departure: __________

Other Countries travelling to:	Duration of stay:

Previous Travel Vaccinations:	Date:

Activities Planned During Travel :

Rural/remote	Snorkelling	High Altitude	Surfing	Camping
Urban/city	Climbing	Diving		

I would define my travel as :

Business/Work	Cruise/Tour Vaccation	Volunteer/Mission	Backpacking	Visiting Family/Friend

Medical Conditions : ☐ None ☐ Yes **If yes, see list below:**

	Yes	No		Yes	No
Emotional/Psychiatric Condition			Recent radiation treatment (last 4 months)		
Seizure Disorder			Immune deficiency		
Lung Condition			Spleen Removed / No spleen		
Migraines			Organ / Bone marrow transplant		
High Blood Pressure			Leukemia / Lymphoma / Recent cancer		
Digestive Problems/Tract Problems			Gallbladder Removed		
Heartburn/Acid Reflux			**Other :**		
Arrhythmia/Heart Condition					
High Cholesterol					

Have you been vaccinated in the past 4 weeks? ☐ Yes ☐ No

If yes, which one?

Do you faint with needles? ☐ Yes ☐ No

Are currently taking any prescribed or over the counter medications?: No ☐ Yes ☐ If Yes, please list

Drug Allergies? No ☐ Yes ☐ If yes, list: ______

Other Allergies? No ☐ Yes ☐ If yes, list: ______

Severe Allergic Reaction (Anaphylactic Reaction)? No ☐ Yes ☐ **If yes, list:** ______

Please check if you are allergic to : ☐ Latex ☐ Eggs ☐ Chicken ☐ Adhesive Bandages

How did you hear of our clinic? ______

Women only: Are you pregnant or planning pregnancy? ______ **Breastfeeding**: No ☐ Yes ☐

FOR CLINIC USE ONLY

****If vaccines are not required or declined, a $40.00 consult fee will be charged.****

Vaccine Fees

	Adult	Child		
			☐ Meningococcal (Menactra)	$140
☐ Dukoral (oral) 1 dose	$45		☐ Prevnar	$120
☐ Dukoral (oral) 2 x 1 dose	$85		☐ Adacel (Tetanus,Diptheria,Pertussis)	$40
☐ Hepatitis A (2 doses) prices per dose	$65	$50	☐ Rabies (Prepaid & Availabiltiy)	$220
☐ Hepatitis B (3 doses) prices per dose	$50		☐ PPD (TB skin test)	$50
☐ Twinrix (Hep A and B) prices per dose	$75		☐ Poilo	$57
☐ HPV Vaccine (to be prepaid)	$210		**Publicly Funded Vaccines**	
☐ Japanese B Encephalitis (2 doses) per dose	$210		☐ Pneumococcal(Polysacharide)	$20
☐ Typhoid Injectable	$55		☐ Pneumococcal Conjugate(Prevnar)	$20
☐ Typhoid Oral	$55		☐ Tetanus/Diptheria (Td)	$20
☐ Yellow Fever	$150		☐ Measles/Mumps/Rubella (MMR)	$20
☐ Shingrix (Shingles)	$150		☐ Influenza	$20
☐ Vivaxim (Hep A and Typhoid)	$110		☐ Meningococcal C	$20
☐ Bexsero	$130		☐ Varivax III (Chicken Pox)	$20

***Some Vaccines require more than one injection. Prices are per injection**

For: Students, seniors >65, and employment purposes, $20 will be charged when no vaccinations are given.

I consent to receiving the vaccines as recommended.

I am aware of the clinic recommendation to remain in the waiting area for a minimum of 15 minutes after vaccinations.

Signature: ______ **Date:** ______

Methods of payment: Debit, Cash, Cheque, Credit Card **(Please note a 2% charge will be added to all credit card transactions)**

Some vaccines require boosters. Which would you prefer for your reminder?

☐ **Phone call** ☐ **Post Card** ☐ **Email** ______