

# Travel Immunization Form

## Employee

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Company: \_\_\_\_\_ Position: \_\_\_\_\_  
 Employment Start Date: \_\_\_\_\_ ID Number: \_\_\_\_\_

## Destinations

Location	Arrival Date	Departure Date	Visited Before?

## Medical History

Doctor: \_\_\_\_\_ Hospital/Clinic: \_\_\_\_\_  
 Previous Medical Issues: \_\_\_\_\_ Dates: \_\_\_\_\_  
 Previous Medications: \_\_\_\_\_ Dates: \_\_\_\_\_  
 Allergies: \_\_\_\_\_  
 Current Medical Issues: \_\_\_\_\_  
 Current Medications: \_\_\_\_\_

## Immunizations

Vaccine	# Required	Dates of Most Recent Vaccination
<input type="checkbox"/> Hepatitis A		
<input type="checkbox"/> Hepatitis B		
<input type="checkbox"/> Hepatitis C		
<input type="checkbox"/> Influenza		
<input type="checkbox"/> Meningococcal		
<input type="checkbox"/> MMR		
<input type="checkbox"/> Polio		
<input type="checkbox"/> Tetanus		
<input type="checkbox"/> Tuberculosis		
<input type="checkbox"/> Typhoid		
<input type="checkbox"/> Varicella		
<input type="checkbox"/> Yellow Fever		