# Keystone Pharmacy's Immunization Services

4021 Cascade Rd SE • Grand Rapids, MI 49546 • Phone (888)852-9792 • Fax (616)464-3469 • Email: info@keystonerx.com

## FOREIGN TRAVEL ITINERARY

The following questions will help us determine which immunizations are required, recommended or suggested for your foreign travel. If a question is not clear, please ask us to explain it.

| | | |
|---|---|---|
| NAME: | | DOB: |
| ADDRESS: | PHONE: | Email: |
| Are family/friends traveling with you in need of immunizations also? | | ☐ YES ☐ NO |
| Name(s): | DOB: | |
| FAMILY PHYSICIAN: | PHONE: | |
| EMERGENCY CONTACT:<br>Name:<br>Phone: | CONTACT WHILE TRAVELING:<br>Name:<br>Phone: | |

| TRAVEL HISTORY | YES | NO | N/A | NOT SURE |
|---|---|---|---|---|
| 1. Have you traveled outside of the country in the last 5 years?<br>If yes, list destination, date:<br>_____<br>_____<br>_____<br>_____ | ☐ | ☐ | ☐ | ☐ |
| 2. Have you received immunizations for foreign travel previously? If yes, which immunizations and what were the approximate dates?<br>_____<br>_____<br>_____ | ☐ | ☐ | ☐ | ☐ |
| 3. Have you ever had a serious reaction after receiving an immunization?<br>If yes, which immunization, explain:_____<br>_____ | ☐ | ☐ | ☐ | ☐ |
| 4. Do you have a chronic health condition?<br>If yes,<br>explain:_____ | ☐ | ☐ | ☐ | ☐ |
| 5. During your prior travel did you suffer from any of the following? | ☐ Traveler's Diarrhea | ☐ Altitude Sickness | ☐ Jet Lag | ☐ Air/Motion Sickness |
| | ☐ Malaria | ☐ Other:<br>_____ | | |

6. Please list all **destinations** and the **dates of departure/return** in the order you will be visiting them (BE SPECIFIC).
Ex. June 1st –June 9th Mexico, Acapulco, Hotel Resort only.

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