

Dr Lena Samuel, MD <sup>TM</sup>  
Travel Health Assessment  
347-369-4812  
www.drlenamd.com

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

Occupation/ Job Title: \_\_\_\_\_

Employer address: \_\_\_\_\_

Email address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Form of payment: ( ) Cash, ( ) AMEX ( ) Visa ( ) M/C ( ) Other

Referred by: \_\_\_\_\_

I understand that Dr. Lena Samuel, M.D. does not accept insurance reimbursement for travel medicine services. I also understand that I am responsible for the total amount of charges for these services

Name: \_\_\_\_\_ Date: \_\_\_\_\_

## TRAVEL MEDICINE VISIT

Name: \_\_\_\_\_ Date of Intake: \_\_\_\_\_ DOB: \_\_\_\_\_

**CONSENT TO RECEIVE VACCINES:**

I, \_\_\_\_\_ request that I \_\_\_\_\_ (patient's name) be administered vaccines. I fully understand the possible and probable dangers and consequences of my/patient receiving the vaccine/s marked below. I nonetheless agree to assume any and all risks associated with the receipt of the vaccine/s. I release and agree to indemnify and hold harmless Dr. Samuel for all injuries, damages and any untoward results from my patient's receipt of vaccine/s. I certify that I have read and fully understand all of the above and that I agree to be bound by each and every term. I have been provided a VIS sheet. Pregnant: Yes No , Advised not to get pregnant for 3 months

\_\_\_\_\_  
Patient's authorized signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Today's date

VITALS: BP \_\_\_\_/\_\_\_\_, P\_\_\_\_, T\_\_\_\_, Wt\_\_\_\_  
Physical Exam:

**Vaccines:**

Hep A	R	L	TD	R	L	JEV	R	L
Hep B	R	L	I POL	R	L	Typhoid oral		
Typhoid	R	L	PPD	R	L			
Menomune	R	L	Varicella	R	L			
Menactra	R	L	MMR	R	L			
YF	R	L	Pneum	R	L			
Influenza	R	L	Rabies	R	L			

CDC/Tropimed recommendations	Vaccines only	RX only
Recom with parent/guardian	Malaria discussed	TD discussed
Info packet given	Yellow book given	VIS sheets given

**Prescriptions Recommended:**

Diarrhea Prophylaxis: Xifaxan Levaquin Zithromax Biaxin Imodium Refused  
 Malaria Prophylaxis Malarone Lariam Doxycycline Refused  
 Altitude Sickness Prophylaxis Diamox Dexamethasone Refused

Patient with no adverse effects at visit

RTC 1/ 2/ 4/ 6 12 months