



• Aris Assimacopoulos MD FIDSA • M. Rabiul Alam MD • Jawad Nazir MD • Manuel Arbo MD • Asad Ansari MD
911 E 20th Street, Suite 505, Sioux Falls, SD 57105
Phone: 605.334.1667 Fax: 605.331.6401 Toll-Free: 866.613.0108

I request the following vaccinations:

- Hepatitis A Yellow Fever Menactra/Meningitis Tetanus/Diphtheria Rabies
 Hepatitis B Typhoid-Oral Typhoid-injectable Polio-injectable

Please read and initial the following to indicate that you understand and agree with these statements:

- _____ I have consulted a reliable source and determined that I require these vaccinations for travel purposes and will not hold Infectious Disease Specialists, P.C. or any of their employees or physicians responsible for determining the necessity or appropriateness of these vaccinations.
- _____ I have received the *CDC Vaccine Information Statement* for each vaccination requested and have read and understood the risks and benefits of each vaccination requested.
(Ask receptionist for forms if you did not receive them.)
- _____ I have no contraindication (reason not to have the vaccine) to any of the requested vaccinations and completed the *Screening Questionnaire for Adult Immunization* without any “Yes” answers.
- _____ I understand that the requested vaccinations may rarely result in severe side effects that may lead to permanent injury and/or death.
- _____ My questions have been answered to my satisfaction.
- _____ I request the above vaccinations **WITHOUT** a travel medicine consultation. I understand that I may request a travel medicine consultation at any time if I am not sure as to whether I should receive any vaccinations or my questions are not fully answered.

Common topics covered in the travel medicine consultation include: Need for new or updated vaccines (Tetanus, Polio, Meningitis, Rabies, Hepatitis A, Hepatitis, B, Typhoid, Yellow Fever, Japanese Encephalitis, Cholera); Contraindications to vaccination; Malaria pills; Food- and water-borne infections; Insect repellents; Travel insurance; Traveler’s diarrhea; Vaccine exemptions; Altitude Sickness; Medical conditions affecting travel.

Signed _____

Date: _____

Print: _____

DOB: ____ / ____ / _____ Age: ____ (Must be 18 or older)