YELLOW FEVER VACCINE REQUEST

Due to manufacturer restrictions, the supply of YF-Vax yellow fever vaccine is currently limited. To use our supply efficiently, we are asking clients to medically pre-qualify for the vaccine; then we will reserve a dose.

Note: To receive a dose of YF-Vax at AITC, you MUST first consult a travel medicine provider regarding your upcoming trip, as international travelers who need YF-Vax also need additional vaccinations, medications, and/or pre-travel counseling. (AITC is not currently offering this service due to the pandemic).

PLEASE DO NOT SUBMIT THIS FORM UNTIL AFTER YOU’VE CONSULTED A TRAVEL MED PROVIDER FOR THIS TRIP

Please answer all questions and PRINT LEGIBLY. Complete a form for each traveler. All fields are required.

*Full Name ___________________________________________ *Age: ____________

*Best telephone number(s) ___________________________________ *Today’s Date ______________

*Email address: _______________________________________

*When was your travel consultation regarding this trip? *Date of Consultation: _______________

*From Provider/Facility (Name): ___________________________ Phone: ______________________

*What countries are you traveling to? List in the order that you will visit & include all layover countries.

1________________________________ 5________________________________
2________________________________ 6________________________________
3________________________________ 7________________________________
4________________________________ 8________________________________

*When is your departure date from the U.S.? ________________

*Are you allergic to eggs? □Yes □No □Not Sure

*Do you have a weakened immune system due to a health condition or medication? □Yes □No □Not Sure

*Have you ever had a yellow fever vaccine before? □Yes □No □Not Sure

If yes, include copy of the certificate, or tell us what year you had it ________

Instructions: Please email a completed form to Travelshots.dph@sfdph.org

With subject line: “Yellow Fever request”

Our staff will contact you upon reviewing your form.

For clinic use only: Reviewed By RN: _____ □ no YF needed □ sched for YFvax □ sched for YFvax waiver
Appt Date: __________________________ Appt Date: __________________________ form ver. 2021-6-17