Manor Park Surgery

Travel Risk Assessment Form

Please complete this form 6 weeks prior to your travel plans, hand to our receptionist when making your travel appointment with the nurse.

Personal Details	
Name:	Date of Birth: Male ☐ Female ☐
Contact Number:	
Email:	
Dates of Journey	
Date of Departure:	
Date of Return:	

Itinerary and purpose of journey		
Country to be visited and location within country	Length of stay	Away from medical help at destination, if so, how remote?
1		
2		
3		

Please tick as appropriate below to best describe your journey						
Type of journey	Business		Pleasure		Other	
Holiday Type	Package		Self-Organised		Backpacking	
	Camping		Cruise Ship		Trekking	
Accommodation	Hotel		Relative/Family home		Other	
Travelling	Alone		With Family/Friends		In a group	
Staying in an area that is	Urban		Rural		Altitude	
Planned activities	Safari		Adventure		Other	

Personal medical History
Do you have any recent or past medical history of note? (incl. diabetes, heart or ling conditions, thymus disorder)
List any current or repeat medications
Do you have any allergies for example to eggs, antibiotics, nuts?
Have you ever had a serious reaction to a vaccine give to you before?
Does having an injection make you feel feint?
Do you or any close family members have epilepsy?
Do you have any history of mental illness including depression or anxiety?
Have you recently undergone radiotherapy, chemotherapy or steroid treatment?
Women only: Are you pregnant or planning pregnancy or breast feeding?
Have you taken out travel insurance and if you have a medical condition, informed the insurance company about this?
Please write below any further information which may be relevant

Vaccination History					
Have you ever had any of the following vaccination/malaria tablets and if so when?					
Tetanus		Polio		Diphtheria	
Typhoid		Hepatitis A		Hepatitis B	
Meningitis		Yellow Fever		Influenza	
Rabies		Jap B Enceph		Tick Bourne	
Other					
Malaria Tablets					

For discussion when risk assessment is performed within your appointment:

I have no reason to think that I might be pregnant. I have received information on the risks and benefits of the vaccines recommended and have had the opportunity to ask questions. I consent to the vaccines being given.

Signed Date