**TRAVEL RISK ASSESSMENT FORM AT WRYTHE GREEN SURGERY**

*On completion of this form, please return it to Reception and make a Travel Appointment – ideally 4 to 6 weeks before you travel. Any fees that are due must be paid on the day in* ***Debit Card*** *or by* ***CHEQUE ONLY.***

|  |  |  |
| --- | --- | --- |
| ***Personal Details*** | | |
| ***Name:*** | | ***Date of Birth:*** |
| ***Best Contact No.*** | | |
| ***Dates of Trip*** | | |
| ***Date of Departure:*** | ***Overall Length of Trip:*** | |
| ***Itinerary*** | | |
| ***Country to be Visited Specific Area/s within that country Length of Stay in Each***  ***1.***  ***2.***  ***3.***  ***4.*** | | |
| ***Please tick √* the descriptions that best describe your trip:** | | |
| ***1.* Type of Trip Business Pleasure Other**  **2. Holiday Type Package Self-Organised Backpacking**  **Camping Cruise Ship Trekking**  **3. Accommodation Hotel Relatives/Family Home Other**  **4. Travelling Alone With Family/Friend In a Group**  **5. Staying in an area which is Urban Rural Altitude**  **6. Planned activities Safari Adventure Other** | | |
| **Personal Medical History**  **Do you have any recent or past medical history of note? This includes diabetes, heart or lung conditions and thymus disorder.** | | |
| **Please list any current or repeat medication:** | | |

|  |  |
| --- | --- |
| Do you have any allergies eg nuts, antibiotics, eggs? | Y/N |
| Have you ever had a serious reaction to a vaccine given to you before? | Y/N |
| Does having an injection make you feel faint? | Y/N |
| Do you or any close family members have epilepsy? | Y/N |
| Do you have any history of mental illness including depression or anxiety? | Y/N |
| Have you recently undergone radiotherapy, chemotherapy or steroid treatment? | Y/N |
| Women Only: Are you pregnant or planning pregnancy or breast feeding? | Y/N |
| Have you taken out travel insurance? If you have a medical condition, have you informed the insurance company about this? | Y/N |
| Please give any further information that may be relevant, including any future travel plans. | |
| ***Vaccination History: Have you ever had any of the following vaccinations/malaria tablets? If so when?*** | |
| Tetanus Polio Diphtheria Typhoid Hepatitis Hepatitis B Tick Bourne  Meningitis Yellow Fever Influenza Rabies Jap B Enceph Malaria Tablets Other | |
| 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 vaccines recommended and have had the opportunity to ask questions. I consent to the vaccines being given.  Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| General health advice for British travellers, please see the 8 Weeks to Go website: **www.8weekstogo.co.uk** | |
| **Vaccination Fees**  **Hepatitis B (course of 3) £35 each Rabies (course of 3) £60 each**  **Meningococcal ACWY £32 Yellow Fever £65**  **Malaria Tablets – if required will be prescribed on a ‘Private Prescription’ at a charge of £15** | |
| **PAYABLE ON THE DAY – DEBIT CARD OR CHEQUES ONLY**  **Failure to have the correct payment will result in vaccines not being administered.**  If you print this form from our online service please ensure to book an appointment with the nurse. | |