THE BURNHAM SURGERY – Travel Vaccination Form

PERSONAL DETAILS	
Name	Date or Birth: Male [ ] Female [ ]
Easiest contact telephone number Email	
DATES OF TRIP	
Date of departure	
Return date or overall length of trip	

ITINERARY AND PURPOSE OF VISIT		
Countries to be visited	Length of stay	Away from Medical Help at destination, if so, how remote ?
1.		
2.		
3.		
Any future travel plans ?		

PLEASE TICK AS APPROPRIATE BELOW TO BEST DESCRIBE YOUR TRIP						
1. Type of trip	Business		Pleasure		Other	
2. Holiday type	Package		Self Organised		Back-packing	
	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 ? (including diabetes, heart or lung conditions)
List any current or repeat medications
Do you have any allergies, for example to eggs, antibiotics, nuts or latex ?
Have you ever had a serious reaction to a vaccine given to you before ?
Does having an injection make you feel faint ?
Do you or any close family members have epilepsy ?
Do you have any history or mental illness including depression or anxiety ?
Have you recently undergone radiotherapy, chemotherapy or steroid treatment ?
Women Only: are you pregnant or planning pregnancy or breastfeeding ?
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 vaccinations / malaria tablets and if so when ?					
Tetanus		Polio		Diptheria	
Typhoid		Hepatitis A		Hepatitis B	
Meningitis		Yellow Fever		Influenza	
Rabies		Jap B Encephalitis		Tick Borne	
Other					
Malaria Tablets					

For discussion when risk assessment is performed within your appointment

I have no reason to think 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: .....

★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ FOR OFFICIAL USE ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★				
Patient Name:				
Travel Risk Assessment performed Yes [ ] No [ ]				
Travel Vaccines recommended for this trip				
Disease Protection	YES	NO	Patient declined vaccine	Further information
Hepatitis A				
Hepatitis B				
Typhoid				
Cholera				
Tetanus				
Diphtheria				
Polio				
Meningitis ACWY				
Yellow Fever				
Rabies				
Japanese B Encephalitis				
Other				

Travel advice and leaflets given as per travel protocol					
Food, water and personal hygiene advice		Travellers' diarrhoea		Blood and bodily fluid infection risks e.g. Hepatitis B	
Insect bite prevention		Animal bites		Accidents	
Insurance		Air travel		Sun and heat protection	
Websites		SMS vaccines reminder service set up			
Travel record card supplied		Other			

Malaria prevention advice and malaria chemoprophylaxis			
Chloroquine and proguanil		Atovaquone + proguanil	
Chloroquine		Mefloquine	
Doxycycline		Malaria advice leaflet given	

Further Information
e.g. weight of child

Authorisation for Patient Specific Direction (PSD) Use					
Assessor's Name:		Signature:		Date:	
Prescriber's Name:		Signature:		Date:	