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| Personal Details  |
| Name: Date of 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 |
| Country to be visited  |  Length of stay  | Away from medical help at destination, if so how remote?  |
| 1. |  |  |
| 2. |  |  |
| Future travel plans: |  |  |
| Please tick as appropriate below to best describe your trip  |
| Type of trip  | Business  |  | Pleasure |  | other |  |
| Holiday type  | Package  |  | Self organised |  | backpacking |  |
| Camping |  | Cruise ship |  | Trekking |  |
| Accommodation  | Hotel  |  | Relatives/family home  |  | other |  |
| Travelling | Alone |  | With family/friend |  | In a group |  |
| Staying in area which is | Urban  |  | Rural  |  | Altitude |  |
| 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? |
| 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 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 vaccinations/malaria tablets and if so when? |
| Tetanus |  | Polio  |  | Diphtheria  |  |
| Typhoid |  | Hepatitis A |  | Hepatitis B |  |
| Meningitis |  | Yellow Fever |  | Influenza |  |
| Rabies |  | Jap B Enceph |  | Tick Bone  |  |
| 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: .

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| FOR OFFICAL USE |
| Patients name: |
| Travel risk assessment performed Yes [ ] No [ ] |
| Travel vaccines recommended for this trip  |
| Disease protection | Yes | No | Further information  |
| Hepatitis A |  |  |  |
| Hepatitis B |  |  |  |
| Thyphoid |  |  |  |
| Cholera |  |  |  |
| Tetanus |  |  |  |
| Diphtheria |  |  |  |
| Polio  |  |  |  |
| Meningitis ACWY |  |  |  |
| Yellow Fever |  |  |  |
| Rabies |  |  |  |
| Japaanese B |  |  |  |
| Encephalitis |  |  |  |
| Other |  |  |  |
| Travel advice and leaflets given as per travel protocol  |
| Food water and personal hygiene advice |  | Travellers’ diarrhoea |  | Hepatitis B and HIV |  |
| Insect bite prevention  |  | Animal Bites |  | Accidents |  |
| Insurance  |  | Air travel |  | Sun and heat protection  |  |
| Websites  | Travel record card supplied |
| other |
| Malaria prevention advice and malaria chemoprophylaxis |
| Chloroquine and proguanil  |  | Atovaquone + Proguanil(Malarone) |  |
| Chloroquine  |  | Mefloquine  |  |
| Doxycycline |  | Malaria advice leaflet given  |  |
| Further information  |
| e.g weight of child |

Signed by: Position: Date: .