

Personal Details					
Name:				Date of Birth (DD/MM/YYYY):	
Contact Telephone Number:				Gender:	
Email:					
Dates of Trip					
Date of Departure:					
Return Date/Trip Length:					
Itinerary and Visit Purpose					
Countries To be Visited:		Length of Stay:		Remoteness from Medical Help:	
1.					
2.					
3.					
Possible Future Travel Plans:					
Description of your Trip – tick as appropriate					
Type of Trip	Business	<input type="checkbox"/>	Pleasure	<input type="checkbox"/>	Other
Holiday Type	Package	<input type="checkbox"/>	Self-Organised	<input type="checkbox"/>	Backpacking
	Camping	<input type="checkbox"/>	Cruise Ship	<input type="checkbox"/>	Trekking
Accommodation	Hotel	<input type="checkbox"/>	Relatives/Family Home	<input type="checkbox"/>	Other
Travelling	Alone	<input type="checkbox"/>	With family/friend	<input type="checkbox"/>	In a group
Staying in area which is	Urban	<input type="checkbox"/>	Rural	<input type="checkbox"/>	Altitude
Planned Activities	Safari	<input type="checkbox"/>	Adventure	<input type="checkbox"/>	Other
Personal Medical History					
Do you have any recent or past medical history of note? (diabetes, heart or lung conditions):					
List any current or repeat medications:					
Do you have any allergies 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 undergone radiotherapy, chemotherapy or steroid treatment?					
Women Only: Are you pregnant, breast-feeding or planning pregnancy?					
Have you take out travel insurance & if you have a medical condition, informed the insurance company about this?					
Any further information which might be relevant:					

Vaccination History					
Have you ever had any of the following vaccination/tablets, if so when?					
Tetanus		Polio		Diphtheria	
Typhoid		Hepatitis A		Hepatitis B	
Meningitis		Yellow Fever		Influenza	
Rabies		Jap B Enceph		Tick Borne	
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: _____

FOR OFFICIAL USE – DOCTOR/NURSE USE ONLY					
Patient Name:					
Travel Risk Form Completed:		Yes		No	
Vaccines Recommended for this Trip					
Disease Protection:	Yes	No	Patient Declined Vaccination:	Further Information:	
Hepatitis A					
Hepatitis B					
Typhoid					
Cholera					
Tetanus					
Diphtheria					
Polio					
Meningitis ACWY					
Yellow Fever					
Rabies					
Japanese B Enceph					
Other – (Specify)					
Travel Advice and Leaflets given as per Travel Protocol					
Food, Water and Personal Hygiene Advice		Travellers' Diarrhoea		Blood and Bodily Fluid Infection risks (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 + Proguanil		Atovaquone + Proguanil			
Chloroquine		Mefloquine			
Doxycycline		Malaria advice Leaflet Given			
Further Information – (weight, height)					
Authorisation for Patient Specific Direction (PSD) Use					
Prescribers Name:		Signature:		Date:	