

Please contact the surgery for a travel appointment one week after returning your form.
PLEASE AIM TO HAVE HOLIDAY VACCINATIONS AT LEAST 4-6 WEEKS PRIOR TO TRAVEL

Personal Details

Surname Date of birth

First Name(s) Male Female

Easiest Contact Telephone No.

Dates of Trip

Date of departure Return date or overall length of trip

Itinerary and Purpose of Visit

Country to be visited	Town	Length of stay	Away from medical help at destination, if so how remote
1 <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2 <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Future travel plans	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Please tick as appropriate below to best describe your trip

1. Type of Trip	Business <input type="checkbox"/>	Pleasure <input type="checkbox"/>	Other <input type="checkbox"/>
2. Holiday Type	Package <input type="checkbox"/>	Self Organised <input type="checkbox"/>	Back-packing <input type="checkbox"/>
	Camping <input type="checkbox"/>	Cruise Ship <input type="checkbox"/>	Trekking <input type="checkbox"/>
3. Accommodation	Hotel <input type="checkbox"/>	Relative/family <input type="checkbox"/>	Other <input type="checkbox"/>
	Alone <input type="checkbox"/>	With family/friend <input type="checkbox"/>	In a group <input type="checkbox"/>
5. Staying in area which is	Urban <input type="checkbox"/>	Rural <input type="checkbox"/>	Altitude <input type="checkbox"/>
6. Planned activities	Safari <input type="checkbox"/>	Adventure <input type="checkbox"/>	Other <input type="checkbox"/>

Personal Medical History

Do you have any recent or past medical history of note? (inc. 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 ins 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	<input type="text"/>	Polio	<input type="text"/>	Diphtheria	<input type="text"/>
Typhoid	<input type="text"/>	Hepatitis A	<input type="text"/>	Hepatitis B	<input type="text"/>
Meningitis	<input type="text"/>	Yellow Fever	<input type="text"/>	Influenza	<input type="text"/>
Rabies	<input type="text"/>	Jap B Enceph	<input type="text"/>	Tick Borne	<input type="text"/>

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

Patient Name

Travel Risk Assessment performed? Yes No

Travel vaccines recommended for this trip

Disease protection	Yes	No	Further information	Patient Specific Direction GP Signature
Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	
Typhoid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	
Tetanus / Diphtheria	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	
Polio	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	
Meningitis ACWY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	
Yellow Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	
Rabies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	
Japanese B Encephalitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	
Tick Born Encephalitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	

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: