

Personal details			
Name:		Date of birth: Male [ ] Female [ ]	
Easiest contact telephone number			
E mail			
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			
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 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?			
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?			
<b>Women only:</b> 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 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**

Patient Name:

Travel risk assessment performed Yes [ ] No [ ]

**Travel vaccines recommended for this trip**

Disease protection	Yes	No	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		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	

**Futher information**

e.g. weight of child

Signed by:

Position:

Date:

Now scan this form into the patient's record on the computer for evidence of best practice