

Personal details						
Name:		Date of Birth:		Male ( )	Female ( )	
Easiest contact telephone number:						
Dates of Trip						
Date of departure						
Return date or overall length of trip						
Details about destination(s)						
Country and location 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	
3. Accommodation	Camping		Cruise ship		Trekking	
4. Travelling	Hotel		Relatives/family home		Other	
5. Staying in area which is	Alone		With family/friend		In a group	
	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?						
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 Borne		
Other						
Malaria tablets						
<p>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.</p>						
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 pre 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						
Weight of child						
Authorisation for Patient Specific Direction (PSD) Use						
Name:		Signature:			Date:	