

## Personal details

Name: \_\_\_\_\_ Date of birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Male  Female   
 Address: \_\_\_\_\_ Contact tel number: \_\_\_\_\_  
 \_\_\_\_\_ Email: \_\_\_\_\_  
 \_\_\_\_\_ Postcode Nationality: \_\_\_\_\_

## Your 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. _____	_____	_____
3. _____	_____	_____
Travel plans in the future		

### Please tick as appropriate below to best describe your trip

- |                             |                                   |   |                                      |
|-----------------------------|-----------------------------------|---|--------------------------------------|
| 1. Type of trip             | <input type="checkbox"/> Business | <input type="checkbox"/> Pleasure           | <input type="checkbox"/> Other       |
| 2. Holiday Type             | <input type="checkbox"/> Package  | <input type="checkbox"/> Self organised     | <input type="checkbox"/> Backpacking |
|                             | <input type="checkbox"/> Camping  | <input type="checkbox"/> Cruise ship        | <input type="checkbox"/> Trekking    |
| 3. Accommodation            | <input type="checkbox"/> Hotel    | <input type="checkbox"/> Relatives family   | <input type="checkbox"/> Other       |
| 4. Traveling                | <input type="checkbox"/> Alone    | <input type="checkbox"/> home               | <input type="checkbox"/> In a group  |
| 5. Staying in area which is | <input type="checkbox"/> Urban    | <input type="checkbox"/> with Family friend | <input type="checkbox"/> Altitude    |
| 6. Planned activities       | <input type="checkbox"/> Safari   | <input type="checkbox"/> Rural              | <input type="checkbox"/> 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 breastfeeding?

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 (tick YES box if you have) and if YES when?

Tetanus	YES <input type="checkbox"/> (When/Date)	Polio	YES <input type="checkbox"/> (When/Date)	Diphtheria	YES <input type="checkbox"/> (When/Date)
Typhoid	YES <input type="checkbox"/> (When/Date)	Hepatitis A	YES <input type="checkbox"/> (When/Date)	Hepatitis B	YES <input type="checkbox"/> (When/Date)
Meningitis	YES <input type="checkbox"/> (When/Date)	Yellow Fever	YES <input type="checkbox"/> (When/Date)	Influenza	YES <input type="checkbox"/> (When/Date)
Rabies	YES <input type="checkbox"/> (When/Date)	Jap B Enceph	YES <input type="checkbox"/> (When/Date)	Tick Borne	YES <input type="checkbox"/> (When/Date)
Other	YES <input type="checkbox"/> (When/Date plus can you add more information)				
Malaria tablets	YES <input type="checkbox"/> (When/Date)				

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

Hepatitis A	<input type="checkbox"/> YES <input type="checkbox"/> NO	More Information
Hepatitis B	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Typhoid	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Cholera	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Tetanus	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Diphtheria	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Polio	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Meningitis ACWY	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Yellow Fever	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Rabies	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Japanese B Encephalitis	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Other	<input type="checkbox"/> YES <input type="checkbox"/> NO	

### Authorisation for - Patient specific Direction (PSD) Use

Assessor's Name \_\_\_\_\_  
 Signature \_\_\_\_\_ Date \_\_\_\_\_

Prescriber's Name \_\_\_\_\_  
 Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Name of Vaccine \_\_\_\_\_  
 Batch \_\_\_\_\_ Expiry \_\_\_\_ / \_\_\_\_ / \_\_\_\_

### Travel advice and leaflets given as per travel protocol

<input type="checkbox"/> Food water and personal hygiene advice	<input type="checkbox"/> Travellers' diarrhoea	<input type="checkbox"/> Hepatitis B & HIV
<input type="checkbox"/> Insect bite prevention	<input type="checkbox"/> Animal bites	<input type="checkbox"/> Accidents
<input type="checkbox"/> Insurance	<input type="checkbox"/> Air travel	<input type="checkbox"/> Sun and heat protection
<input type="checkbox"/> Websites	<input type="checkbox"/> Travel Record card supplied	
	<input type="checkbox"/> Other	

### Malaria prevention advice and malaria chemoprophylaxis

<input type="checkbox"/> Chloroquine and proguanil	<input type="checkbox"/> Atovaquone + proguanil (Malarone)
<input type="checkbox"/> Chloroquine	<input type="checkbox"/> Mefloquine
<input type="checkbox"/> Doxycycline	<input type="checkbox"/> Malaria advice leaflet given

### Further information

e.g. weight of child

Signed by: \_\_\_\_\_ Position \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_