jabs Travel Clinic

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	☐ Business	☐ Pleasure	☐ Other
2. Holiday Type	☐ Package	☐ Self organised	☐ Backpacking
	☐ Camping	☐ Cruise ship	☐ Trekking
3. Accommodation	☐ Hotel	☐ Relatives family	☐ Other
4. Travelling	☐ Alone	☐ home	☐ In a group
5. Staying in area which is	☐ Urban	☐ with Family friend	☐ Altitude
6. Planned activities	☐ Safari	☐ Rural	☐ 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 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 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?

Vaccination	YES	(When/Date)	Vaccination	YES	(When/Date)	Vaccination	YES	(When/Date)
Tetanus	☐		Polio	☐		Diphtheria	☐	
Typhoid	☐		Hepatitis A	☐		Hepatitis B	☐	
Meningitis	☐		Yellow Fever	☐		Influenza	☐	
Rabies	☐		Jap B Enceph	☐		Tick Borne	☐	

Other YES ☐ (When/Date plus can you add more information)

Malaria tablets YES ☐ (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

Vaccine	YES	NO	More Information
Hepatitis A	☐	☐	
Hepatitis B	☐	☐	
Typhoid	☐	☐	
Cholera	☐	☐	
Tetanus	☐	☐	
Diphtheria	☐	☐	
Polio	☐	☐	
Meningitis ACWY	☐	☐	
Yellow Fever	☐	☐	
Rabies	☐	☐	
Japanese B Encephalitis	☐	☐	
Other	☐	☐	

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

- ☐ Food water and personal hygiene advice
- ☐ Insect bite prevention
- ☐ Insurance
- ☐ Websites
- ☐ Travellers' diarrhoea
- ☐ Animal bites
- ☐ Air travel
- ☐ Travel Record card supplied
- ☐ Hepatitis B & HIV
- ☐ Accidents
- ☐ Sun and heat protection
- ☐ Other

Malaria prevention advice and malaria chemoprophylaxis

- ☐ Chloroquine and proguanil
- ☐ Chloroquine
- ☐ Doxycycline
- ☐ Atovaquone + proguanil (Malarone)
- ☐ Mefloquine
- ☐ Malaria advice leaftlet given

Further information

e.g. weight of child

Signed by: ____________________ Position ____________________ Date: / /