**Travel Vaccination Form – One form per person**

Some vaccinations must be given prior to travel in order for them to be effective. It is important that you complete and submit the travel request for at least 6 weeks before departing ensuring you are fully protected.

**Please complete ALL information**

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| **Personal Details** |
| Name Date of Birth  | Male Female  |
| Contact Number | Email |
| **Dates of Trip** |
| Departure date | Return date or overall length of trip |
| **Details of destination (s)** |
| Country and location to be visited | Length of stay | Away from medical help at destination, if so, how remote? |
| 1. |  |  |
| 2. |  |  |
| 3 |  |  |
| Do you plan to travel abroad again 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 home |  | Other |  |
| 4. Travelling | Alone |  | With family/ friends |  | In a group |  |
| 5. Is/are the area/s  | 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 or latex? |
| Have you ever had a serious reaction to a vaccine given to you before? |
| Does having an injection made 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 radio/chemo therapy 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 |

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| **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 Bourne |  |
| 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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **FOR OFFICIAL USE ONLY** |
| **Patient Name:**  |
| Travel risk assessment performed Yes [ ] No [ ]  |
| **Travel Vaccines recommended for this trip**  |
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| --- | --- | --- | --- | --- |
| **Disease protection** | **Yes** | **No** | **Patient declined vaccine** | **Vaccine name, dose & Schedule for PSD** |
| Hepatitis A  |  |  |  |  |
| Hepatitis B  |  |  |  |  |
| Typhoid |  |  |  |  |
| Cholera |  |  |  |  |
| Tetanus |  |  |  |  |
| Diphtheria |  |  |  |  |
| Polio |  |  |  |  |
| Meningitis ACWY |  |  |  |  |
| Yellow Fever |  |  |  |  |
| Rabies |  |  |  |  |
| Japanese B Encephalitis |  |  |  |  |
| Other |  |  |  |  |

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| **Travel advice and leaflets given as per travel protocol** |
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|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Food water and personal hygiene advice |  | Traveller’s diarrhoea |  | Blood and bodily fluid infection risks e.g. Hepatitis B |  |
| Insect bite prevention |  | Animal bites |  | Accidents |  |
| Insurance |  | Air travel |  | Sun and heat protection |  |
| Websites |  | SMS Vaccines reminder service set up |  |
| Travel record card supplied |  | Other |
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| **Malaria prevention advice and malaria chemoprophylaxis** |
| Chloroquine and proguanil |  | Atovaquone + proguanil (Malarone) |  |
| Chloroquine |  | Mefloquine |  |
| Doxycycline |  | Malaria advice leaflet given |  |

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| **Further information** |
| e.g. weight of child

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| **Authorisation for Patient specific Direction (PSD) use** |
| **Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

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