**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**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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 | | | | | | | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |
| --- |
| **FOR OFFICIAL USE ONLY** |
| **Patient Name:** |
| Travel risk assessment performed Yes [ ] No [ ] |
| **Travel Vaccines recommended for this trip** |
| |  |  |  |  |  | | --- | --- | --- | --- | --- | | **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 |  |  |  |  | |
| **Travel advice and leaflets given as per travel protocol** |
| |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | 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 | | | | |  | | | | | | |  | | | | | |  |  |  |  |  | | --- | --- | --- | --- | | **Malaria prevention advice and malaria chemoprophylaxis** | | | | | Chloroquine and proguanil |  | Atovaquone + proguanil (Malarone) |  | | Chloroquine |  | Mefloquine |  | | Doxycycline |  | Malaria advice leaflet given |  |  |  | | --- | | **Further information** | | e.g. weight of child   |  | | --- | | **Authorisation for Patient specific Direction (PSD) use** | | **Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |