Friends Road Medical Practice

Travel Vaccination Form

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:

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.		
4.		
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	
	Camping		Cruise ship		Trekking	
3. Accommodation	Hotel		Relative/family home		Other	
4. Travelling	Alone		With family/friend		In a group	
5. Staying in area which is	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 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 breast feeding?
Women only: I have no reason to think that I might be pregnant - **Signature:**
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		Diptheria	
Typhoid		Hepatitis A		Hepatitis B	
Meningitis		Yellow Fever		Influenza	
Rabies		Jap B Enceph		Tick Borne	
Other					
Malaria tablets					

For discussion when risk assessment is performed within your appointment:

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 ~ To be completed by the Practice							
Patient Name:							
Travel risk assessment performed Yes [ ] No [ ]							
Travel vaccines recommended for this trip							
Disease protection	Yes	No	Further information	Disease protection	Yes	No	Further information
Hepatitis A				Polio			
Hepatitis B				Meningitis ACWY			
Typhoid				Yellow Fever			
Cholera				Rabies			
Tetanus				Jap B Enceph			
Diphtheria				Other			

Travel advice and leaflets given as per travel protocol					
Food, water & personal hygiene advice		Travellers' diarrhoea		Hepatitis B & HIV	
Insect bite protection		Animal bites		Accidents	
Insurance		Air travel		Sun & 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
e.g. weight of child
Any other comments:
Signed by: Position: Date:

Note: *Scan completed form into the patient's EMR for evidence of best practice*