Please complete and return to the surgery. Please note that it is your responsibility to telephone the surgery to book your travel appointment

PERSONAL DETAILS	
Name	Date of birth Male [ ] Female [ ]
Easiest contact telephone no:	
Email	

DATE 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.		
Future travel plans		

Please tick as appropriate below to best describe your trip			
Type of trip	Business [ ]	Pleasure [ ]	Other [ ]
Holiday type	Package [ ] Camping [ ]	Self organized [ ] Cruise ship [ ]	Backpacking [ ] Trekking [ ]
Accommodation	Hotel [ ]	Relatives/ family home [ ]	Other [ ]
Travelling	Alone [ ]	With family/friend [ ]	In group [ ]
Staying in area which is	Urban [ ]	Rural [ ]	Altitude [ ]
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 eg. to eggs, antibiotics or 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 of your 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, planning pregnancy or breast feeding?	
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 borne Enceph	
Other					
Malaria tablets					

For discussion when risk assessment is performed within your appointment:
I have no reason to think that I may 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			
Disease protection	Yes	No	Further information
Hepatitis A			
Hepatitis B			
Typhoid			
Cholera			
Tetanus			
Diphtheria			
Polio			
Meningitis ACWY			
Yellow Fever			
Rabies			
Japanese B Enceph			
Other			

TRAVEL ADVICE AND LEAFLETS GIVEN AS PER TRAVEL PROTOCOL					
Food water and personal hygiene advice		Travellers diarrhoea		Hepatitis B and HIV	
Insect bite prevention		Animal bites		accidents	
insurance		Air travel		Sun and heat protection	

Websites	Travel record card supplied
	Other

MALARIA PREVENTION ADVICE GIVEN AS PER TRAVEL PROTOCOL			
Chloroquine and proguanil		Atovaquone + proguanil (malarone)	
Chloroquine		Mefloquine	
doxycycline		Malaria advice leaflet given	

FURTHER INFORMATION: e.g. weight of child

Signed by: position date