# PATIENT FORM FOR TRAVEL VACCINATIONS

| **Personal Details** | |
|---|---|
| Name: | Date of Birth:<br>Male [ ] Female [ ] |
| Easiest Contact Number: | |
| Email: | |

| **Dates of Trip** |
|---|
| Date of Departure: |
| Return date or overall length of trip: |

| **Itinerary & 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** | | | | | | |
|---|---|---|---|---|---|---|
| 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/friend | | In a group | |
| 5. Staying in an 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? |
| Have you taken out travel insurance and if you have a medical condition, informed the insurance company? |
| 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 Bone | |
| 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 vaccinations 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 Encephalitis | | | |
| Other | | | |

| Travel advice and leaflets given as per travel protocol | | | | |
|---|---|---|---|---|
| Food water & personal hygiene advice | | Travellers diarrhoea | | Hepatitis B & HIV |
| Insect Bite prevention | | Animal bites | | Accidents |
| Insurance | | Air travel | | Sun & heat protection |
| Wesites | | 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 |
|---|
| eg weight of child: |

| Authorised for Patient Specific Direction (PSD) Use | | |
|---|---|---|
| Name: | Signature: | Date: |