

BOURNE GALLETLY PRACTICE

TRAVEL VACCINATION FORM

Please try and give us at least two months' notice (some vaccination courses require at least this amount of time)

Your Details:

Name:	Date of Birth:	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Address:			
Postcode:		Contact Number:	

Trip Details:

Date of Departure:	Return Date or Length of Stay:
--------------------	--------------------------------

Itinerary and Purpose of Visit (please include additional countries on a separate sheet if necessary)

Country to be Visited:	Length of Stay:	Distance to Nearest Medical Help, if none available locally
1.		
2.		

Please Describe Your Trip (tick all that apply)

1. Type of trip	<input type="checkbox"/> Business	<input type="checkbox"/> Pleasure	<input type="checkbox"/> Other:
	<input type="checkbox"/> Package	<input type="checkbox"/> Cruise Ship	<input type="checkbox"/> Self Organised
2. Activities Planned	<input type="checkbox"/> Camping	<input type="checkbox"/> Backpacking	<input type="checkbox"/> Trekking
	<input type="checkbox"/> Safari	<input type="checkbox"/> Adventure	<input type="checkbox"/> Other:
3. Accommodation	<input type="checkbox"/> Hotel	<input type="checkbox"/> Relatives/Family home	<input type="checkbox"/> Other:
4. Type of Area	<input type="checkbox"/> Urban	<input type="checkbox"/> Rural	<input type="checkbox"/> At Altitude
5. Travelling	<input type="checkbox"/> Alone	<input type="checkbox"/> with Family/Friend	<input type="checkbox"/> In a group

Personal Medical History

Please list any recent or past medical history:
Please list your current medication:
Do you have any allergies, including egg, nuts, antibiotics (if yes please list them) <input type="checkbox"/> No <input type="checkbox"/> Yes
Your current weight in Kg:
Have you reacted to any previous vaccinations? <input type="checkbox"/> No <input type="checkbox"/> Yes
Do you have any problems with injections? <input type="checkbox"/> No <input type="checkbox"/> Yes
Have you recently undergone radiotherapy, chemotherapy or steroid treatment? <input type="checkbox"/> No <input type="checkbox"/> Yes
Women only: Are you pregnant, planning pregnancy or breast feeding? <input type="checkbox"/> No <input type="checkbox"/> Yes
Have you taken out travel insurance, and if you have any medical conditions have you informed the insurance company about them? <input type="checkbox"/> No <input type="checkbox"/> Yes
Please list any further relevant information below:

BOURNE GALLETLY PRACTICE

TRAVEL VACCINATION FORM

Vaccination History

Please state when you last had any of the following vaccinations or Malaria tablets:			
<input type="checkbox"/> Tetanus	Date:	<input type="checkbox"/> Hepatitis A (single Vaccine)	Date:
<input type="checkbox"/> Typhoid	Date:	<input type="checkbox"/> Hepatitis A (Booster)	Date:
<input type="checkbox"/> Meningitis C	Date:	<input type="checkbox"/> Hepatitis B (Full Course of 3)	Date:
<input type="checkbox"/> Rabies	Date:	<input type="checkbox"/> Japanese Encephalitis	Date:
<input type="checkbox"/> Polio	Date:	<input type="checkbox"/> Tick Borne Encephalitis	Date:
<input type="checkbox"/> Diphtheria	Date:	<input type="checkbox"/> Influenza	Date:
<input type="checkbox"/> Yellow Fever	Date:	<input type="checkbox"/> Malaria Tablets	Date:
<input type="checkbox"/> Tuberculosis (BCG)	Date:	<input type="checkbox"/> Other:	Date:

Consent (to be completed during your appointment)

I confirm that the information I have given is correct. I have received information about the risks and benefits of the vaccinations recommended and have had the opportunity to ask questions. I consent to the vaccinations recommended below:	
Patient/Guardian Signature:	Date:

For official Use Only

Travel Risk Assessment Done: <input type="checkbox"/> Yes <input type="checkbox"/> No	Vaccinations to commence on or before:
--	--

Travel Vaccine Recommended for this trip:

<input type="checkbox"/> Hepatitis A
<input type="checkbox"/> Hepatitis B
<input type="checkbox"/> Typhoid
<input type="checkbox"/> Cholera
<input type="checkbox"/> Tetanus
<input type="checkbox"/> Diphtheria
<input type="checkbox"/> Polio
<input type="checkbox"/> Meningitis ACWY
<input type="checkbox"/> Yellow Fever
<input type="checkbox"/> Rabies
<input type="checkbox"/> Japanese Encephalitis
<input type="checkbox"/> Tick Borne Encephalitis

Travel Advice and Leaflets:

<input type="checkbox"/> Food, Water, Personal Hygiene	<input type="checkbox"/> Travellers' Diarrhoea	<input type="checkbox"/> Hepatitis and HIV
<input type="checkbox"/> Insect bite prevention	<input type="checkbox"/> Animal Bites	<input type="checkbox"/> Accidents
<input type="checkbox"/> Insurance	<input type="checkbox"/> Air Travel	<input type="checkbox"/> Sun and Heat Protection
<input type="checkbox"/> Websites	<input type="checkbox"/> Travel Record Supplied	<input type="checkbox"/> Other

Malaria Prevention Advice and Prophylaxis

<input type="checkbox"/> Chloroquine and Proguanil	<input type="checkbox"/> Chloroquine	<input type="checkbox"/> Mefloquine
<input type="checkbox"/> Atovaquone and Proguanil (Malarone)	<input type="checkbox"/> Doxycycline	<input type="checkbox"/> Malaria Advice Leaflet

Authorised by:

Signed:	Position:	Date:
---------	-----------	-------