BOURNE GALLETLY PRACTICE

TRAVEL VACCINATION FORM

DATE:……

Appt Date:	Appt Time:	Nurse:	EMIS ID:

Please allow at least two months' notice

(some vaccination courses require at least this amount of time)

There will be a non-refundable travel consultation fee of £25 charged for this service which is payable by cash or card at reception

Patient Details:

Name:	Date of Birth:	☐ Male ☐ 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.		
3.		
4.		

Please Describe Your Trip (tick all that apply)

1. Type of trip	☐ Business	☐ Pleasure	☐ Other:
	☐ Package	☐ Cruise Ship	☐ Self Organised
2. Activities Planned	☐ Camping	☐ Backpacking	☐ Trekking
	☐ Safari	☐ Adventure	☐ Other:
3. Accommodation	☐ Hotel	☐ Relatives/Family home	☐ Other:
4. Type of Area	☐ Urban	☐ Rural	☐ At Altitude
5. Travelling	☐ Alone	☐ with Family/Friend	☐ 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) ☐ No ☐ Yes
Your current weight in Kg:
Have you reacted to any previous vaccinations? ☐ No ☐ Yes
Do you have any problems with injections? ☐ No ☐ Yes
Have you recently undergone radiotherapy, chemotherapy or steroid treatment? ☐ No ☐ Yes
Women only: Are you pregnant, planning pregnancy or breast feeding? ☐ No ☐ Yes
Have you taken out travel insurance, and if you have any medical conditions have you informed the insurance company about them? ☐ No ☐ Yes
Please list any further relevant information below:

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Vaccination History

Please state when you last had any of the following vaccinations or Malaria tablets:			
☐ Tetanus	Date:	☐ Hepatitis A (single Vaccine)	Date:
☐ Typhoid	Date:	☐ Hepatitis A (Booster)	Date:
☐ Meningitis C	Date:	☐ Hepatitis B (Full Course of 3)	Date:
☐ Rabies	Date:	☐ Japanese Encephalitis	Date:
☐ Polio	Date:	☐ Tick Borne Encephalitis	Date:
☐ Diphtheria	Date:	☐ Influenza	Date:
☐ Yellow Fever	Date:	☐ Malaria Tablets	Date:
☐ Tuberculosis (BCG)	Date:	☐ 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: ☐ Yes ☐ No	Vaccinations to commence on or before:

Travel Vaccine Recommended for this trip:

☐ Hepatitis A
☐ Hepatitis B
☐ Typhoid
☐ Cholera
☐ Tetanus
☐ Diphtheria
☐ Polio
☐ Meningitis ACWY
☐ Yellow Fever
☐ Rabies
☐ Japanese Encephalitis
☐ Tick Borne Encephalitis

Travel Advice and Leaflets:

☐ Food, Water, Personal Hygiene	☐ Travellers' Diarrhoea	☐ Hepatitis and HIV
☐ Insect bite prevention	☐ Animal Bites	☐ Accidents
☐ Insurance	☐ Air Travel	☐ Sun and Heat Protection
☐ Websites	☐ Travel Record Supplied	☐ Other

Malaria Prevention Advice and Prophylaxis

☐ Chloroquine and Proguanil	☐ Chloroquine	☐ Mefloquine
☐ Atovaquone and Proguanil (Malarone)	☐ Doxycycline	☐ Malaria Advice Leaflet

Authorised by:

Signed:	Position:	Date: