VACCINATION FORM

PERSONAL DETAILS

Name: .... Date of birth: ....

Contact telephone number: .... Male ☐ Female ☐

Email address: ....

DATES OF TRIP

Date of departure: ....

Return date or overall length of trip: ....

ITINERY AND PURPOSE OF VISIT

Country to be visited	Length of stay	Away from medical help at destination, if so, how remote?
1.		
2.		

TRIP DESCRIPTION

TYPE OF TRIP	Business		Pleasure		Other	
HOLIDAY TYPE	Package		Self-organised		Backpacking	
	Camping		Cruise ship		Trekking	
ACCOMODATION	Hotel		Relatives/family home		Other	
TRAVELLING	Alone		With family/friend		In a group	
STAYING IN A 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? ....

List any current or repeat medications: ....

Do you have any allergies (e.g. eggs, nuts, antibiotics) ....

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 breast feeding? ....

Have you taken out travel insurance and if you have a medical condition, informed the insurance company? ....

Please write any further information which may be relevant: ....

....

PLEASE TURN OVER

VACCINATION HISTORY

Have you ever had any of the following vaccinations/malaria tablets (if so, please state when)

Tetanus		Polio		Diphtheria	
Typhoid		Hepatitis A		Hepatitis B	
Menengitis		Yellow Fever		Influenza	
Rabies		Jab B Enceph		Tick Borne	
Malaria Tablets		Other		Other	

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 reccommended 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 RECCOMENDED FOR THIS TRIP

DISEASE PROTECTION	YES	NO	FURTHER INFORMATION
Hepatitis A			
Hepatitis B			
Typhoid			
Cholera			
Tetanus			
Diphtheria			
Polio			
Menengitis ACWY			
Yellow Fever			
Rabies			
Japanese B Encephalitis			
Other			

TRAVEL ADVICE AND LEAFLETS GIVEN AS PER TRAVEL PROTOCOL

Food water and personal hygiene advice		Traveller's diarrhoea		Hepatitis B and HIV	
Insect bite protection		Animal bites		Accidents	
Insurance		Air travel		Sun and heat protection	

MALARIA PREVENTION ADVICE AND MALARIA CHEMOPROPHYLAXIS

Chloroquine and proguanil		Atovaquone + proguanil	
Chloroquine		Mefloquine	
Doxycycline		Malaria advice leaflet given	

FURTHER INFORMATION

Signed by (GP): Date:

Signed by (Practice Nurse): Date: