|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Lakeside & Grappenhall Surgery**  **Travel Vaccine Form** | | | | | | | | | **Date Received** | | | | |  | | | |
| **Admin Initials** | | | | |  | | | |
| **Personal details** | | | | | | | | | | | | | | | | | |
| Name:  Address: | | | | | | | | | | | Date of birth:  Male [ ] Female [ ] | | | | | | |
| Easiest contact telephone number | | | | | | | | | | | | | | | | | |
| **Dates of trip** | | | | | | | | | | | | | | | | | |
| Date of Departure | | | | | | | | | | | | | | | | | |
| Return date or overall length of trip | | | | | | | | | | | | | | | | | |
| **Itinerary and purpose of visit** | | | | | | | | | | | | | | | | | |
| Country & area to be visited in order of trip | | | | | Length of stay | | | | | Away from medical help at destination, if so, how remote? | | | | | | | |
| 1. | | | | |  | | | | |  | | | | | | | |
| 2. | | | | |  | | | | |  | | | | | | | |
| 3. | | | | |  | | | | |  | | | | | | | |
| 4. | | | | |  | | | | |  | | | | | | | |
| 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 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 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 or mental illness including depression or anxiety? | | | | | | | | | | | | | | | | | |
| Have you recently undergone radiotherapy, chemotherapy or steroid treatment? | | | | | | | | | | | | | | | | | |
| Do you have a condition that may suppress your immune system e.g. lymphoma, Hodgkin disease, HIV | | | | | | | | | | | | | | | | | |
| ***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 about this? | | | | | | | | | | | | | | | | | |
| Please write below any further information which may be relevant. | | | | | | | | | | | | | | | | | |
| **Please complete the following section of your immunisation history.** | | | | | | | | | | | | | | | | | |
| Imms | | | Date Immunised | | | | Never had | | | | | Don’t know | | | | |
| Tetanus | | |  | | | |  | | | | |  | | | | |
| Diphtheria | | |  | | | |  | | | | |  | | | | |
| Polio | | |  | | | |  | | | | |  | | | | |
| Typhoid | | |  | | | |  | | | | |  | | | | |
| Hepatitis A | | |  | | | |  | | | | |  | | | | |
| Yellow Fever | | |  | | | |  | | | | |  | | | | |
| Hepatitis B | | |  | | | |  | | | | |  | | | | |
| Rabies | | |  | | | |  | | | | |  | | | | |
| Meningitis ACWY | | |  | | | |  | | | | |  | | | | |
| Japanese B Encephalitis | | |  | | | |  | | | | |  | | | | |
| Tick borne encephalitis | | |  | | | |  | | | | |  | | | | |
| |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | FOR OFFICIAL USE Appt Date:………………………Appt Time:…………………………. | | | | | | | | | | | | 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 and personal hygiene advice |  | Traveller’s diarrhoea | | | | |  | Hepatitis B and HIV | |  | | Insect bite prevention |  | Animal bites | | | | |  | Accidents | |  | | Insurance |  | Air travel | | | | |  | Sun and heat protection | |  | | Websites:  [www.fitfortravel.nhs.uk](http://www.fitfortravel.nhs.uk/)  [www.travelhealthpro.org.uk](http://www.travelhealthpro.org.uk/) | | 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 | | | | | | | | | | | | e.g. weight of child | | | | | | | | | | | | | | | | | | | | | | | | | |

Signed by: Position: Date:

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