TRAVEL FORM

Personal details			
Name:		Date of birth: Male Female	
Easiest contact telephone number: Email:			
Dates of trip			
Date of departure:			
Return date or overall length of trip:			
Itinerary and purpose of visit			
Countries to be visited 1. 2. 3.			Length of stay
Away from medical help at destination, if so, how remote?			
Any future travel plans?			
Please circle as appropriate below to best describe your trip			
1. Type of trip	Business	Pleasure	Other
2. Holiday type	Package Camping	Self organised Cruise ship	Backpacking Trekking
3. Accommodation	Hotel	Relatives/family home	Other
4. Travelling	Alone	With family/friend	Other
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 or latex?			
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 or mental illness including depression or anxiety?			
Have you recently undergone radiotherapy, chemotherapy or steroid treatment?			
Women only: Are you pregnant or breastfeeding?			
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			
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 Borne:	
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 vaccines being given.

Signed…….. Date……

Authorisation for Patient Specific Direction (PSD) Use

Assessor's Name……Signature……Date……

Prescriber's Name……..Signature……Date……