Travel Vaccination Questionnaire

Please complete this form and return it to the receptionist for the Practice Nurse to review.

Personal Details								
Name:			Date of birth: Male () For			Femal	e ()	
Telephone number:		Email:						
Dates of trip								
Date of departure:								
Return date or overall leng	gth of trip:							
Country to be visited in	order	Length	of stay in da	ays Stayir	ng in a	remot	e area	?
1.								
2.								
3.								
4.								
5.								
Please tick at appropriat	te below t	o best d	lescribe you	r trip:				
Types of trip	Business		Pleasure		Other			
Holiday type	Package		Self-organised		Backpacking			
	Camping		Cruise ship		Trekking			
Accommodation	Hotel		Relatives/family home		Other			
Travelling	Alone		With family/friend		In a group			
Staying in area which is	Urban		Rural		Altitude			
Planned activities	Safari		Adventure			-		
Flatilieu activities	Salali		Adventure		(Other		
Are you, or do you have		e follow				Other NO	Y	'ES
		e follow					Y	ES
Are you, or do you have	any of th						Y	ES
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To sign and date when risk assessment has been 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 opportunity to ask questions. I consent to the vaccines being given.

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Signed:	Date:

Patient Name: Travel risk assessment performed: YES() NO() Travel vaccinations recommended for this trip Disease protection Yes No Further information Hepatitis A Hepatitis B Typhoid Cholera Tetanus Diptheria Polio Meningitis ACWY Yellow Fever Rabies Japanese Encephalitis Other: Travel advice and leaflets given as per travel protocol Food water and personal hygiene advice Travellers' diarrhoea Blood and bodily infection risks, e.g. Hepatitis B and HIV Insect bite prevention Animal bites Accidents Insurance Air travel Sun and heat protection Websites Travel records card supplied Other: Malaria prevention advice and malaria chemoprophylaxis Chloroquine + proguanil Chloroquine Doxycycline Atovaquone + proguanil Metfloquine Malaria advice leaflet given Signed by: Date:	FOR PRACTICE NURSE TO COMPLETE:								
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