Travel Risk Assessment Form

Personal details

Name……. Tel no…….

Date of Birth……..... Male/Female…….

Dates of travel ……..

Disclaimer : Please note that advice given is based on the details you give on this form. It is your responsibility to give all relevant information.

Country to be visited	Length of stay	Away from medical help at destination? If so, how remote?

Please circle the descriptions that 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 an area which is	Urban	Rural	Altitude
6. Planned activities	Safari	Adventure	Other

Personal Medical History

Do you have any allergies for example to eggs, antibiotics, nuts?.....

Have you ever had a serious reaction to a vaccine given to you before?.....

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/immunocompromised?…….

Have you taken out travel insurance? If you have a medical condition, have you informed the insurance

company about this?.....

Vaccinations received previously (if known)……...

Please give any information that may be relevant including any future travel plans

…….

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Women only: I have no reason to think I may be pregnant and am not planning a pregnancy or breast feeding.
All: The information given on this form is accurate and complete to the best of my knowledge.

Signed: **Date:**

Travel Vaccine Information Card

Patient Name D.O.B.

Travel Risk Assessment performed Yes ( ) No ( )

TRAVEL VACCINES RECOMMENDED FOR THIS TRIP

Disease protection	Yes	No	Further information
Hepatitis A			
Hepatitis B			
Typhoid			
Tetanus /Diphtheria/Polio			
Meningitis ACWY			
Cholera			
Yellow Fever			
Rabies			
Japanese B Encephalitis			
Other			

GP consent given for administration of vaccine as indicated above

Signed……..Dated……

GP name……