**TRAVEL VACCINATION QUESTIONNAIRE**

You may require travel vaccinations if you are travelling abroad. To help us advise you, please complete this form and return it as soon as possible. Please allow **5 days** after returning the form before contacting the surgery to check if you need an appointment.

**PLEASE ALLOW AT LEAST 8 WEEKS BEFORE YOU TRAVEL.**

**If your travel is imminent you are advised to seek advice from a Private Travel clinic if we are unable to offer you an appointment.**

We are only able to offer vaccinations available on the NHS. All other vaccines are provided via Private Vaccination Clinics.

**PLEASE NOTE, ONE FORM PER TRAVELLER**

Name:

Date of Birth:

Address:

Mobile Tel:

**YOUR HEALTH**

Are you pregnant, planning a pregnancy, or breastfeeding?

YES/NO

Please specify if you have ever had an adverse reaction to a vaccination or anti-malaria medication

YES/NO

Have you obtained travel insurance for this trip?

YES/NO

**Please complete your travel destination, including stopovers, in the table below: and enclose an itinerary (if complex) along with any record of vaccines given elsewhere.**

|  |  |  |  |
| --- | --- | --- | --- |
| **COUNTRY** | **AREA/TOWN** | **FROM (DATE)** | **TO (DATE)** |
|  |  |  |  |
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**YOUR TRAVEL**

Will you be staying in a

hotel

apartment

cruise ship

camping-hostels

backpacking

charity aid work

staying with family

business trip *(Delete as appropriate)*

Do you plan any potentially hazardous activities or trips away from main tourist areas?

YES/NO

If so, what?

**PATIENT CONSENT**

I confirm the information given on this form is correct to the best of my knowledge, and request advice on Travel Health and Immunisation appropriate to the proposed trip.

Signed:

Date:

***PRACTICE USE ONLY***

**VACCINATIONS REQUIRED**

**PATIENT NAME:…………………………..…..................... DOB:………………………**

**20 min appt 40 min appt**

**START INJECTION ON OR BEFORE…………………………………..**

|  |
| --- |
| **AT LEAST 4-8 WEEKS BEFORE TRAVEL**  **\*\*Private vaccines/medicines** – Only available at Private travel clinics  \*\*HEPATITIS B \*\*JAPANESE B ENCEPHALITIS  \*\*RABIES \*\*TICK-BOURNE ENCEPHALITIS  \*\*MENINGITIS ACWY \*\*CHOLERA  \*\*YELLOW FEVER (at least 10 days before travel)  \*\* MALARIA MEDICATION - - Low risk bite prevention only [ ]   * Medication Advised [ ] |
| **NHS VACCINATION AT LEAST 2 WEEKS BEFORE TRAVEL**  1st HEPATITIS A 1st TYPHOID |
| **ANY TIME BEFORE TRAVEL**  DIP, TET & POLIO BOOSTER HEPATITIS A BOOSTER  TYPHOID BOOSTER FLU / MMR |
| Other identified risks:  Zika Dengue Schistosomiasis |

Signature of Nurse…………………………… Date form completed………………

In case of anaphylaxis following immunisation, consent is given for administration of adrenaline at the appropriate dose in line with the current Resuscitation Council anaphylaxis algorithm.

Signature of Doctor……………………………… Date…………………………………

Doctor consent for nurse to vaccinate