

Dear Traveller

You may require vaccinations if travelling abroad. Please complete this questionnaire and return to the surgery at least **8 weeks prior to travel** to assist the Practice Nurse in advising on the required vaccinations. Please contact the surgery 14 days after submitting this form to find out what the nurse has suggested for your travel, and book an appointment if necessary.

Please remember that we are unable to offer vaccinations for business travel and advise anybody travelling for this purpose to source vaccinations from an occupational health department or private travel clinic.

We would also like to advise all travelers to access **travelhealthpro.org.uk** where you are able to access current country recommendations and relevant advice sheets.

When completing the questionnaire please note the following:

1. **Please provide as much information as possible about your planned trip e.g. cities you are visiting, how long you are on safari etc. If you have an itinerary please provide us with a copy**.

**2. Some injections can take 2-3 weeks to provide you with adequate protection so do not leave it until last minute to attend for your vaccinations**

**3. You may need more than one appointment to provide the advice and cover you require.**

**4. There is a charge for some vaccinations e.g. Hepatitis B, rabies, Japanese encephalitis, malaria tablets etc. You will be asked for payment before receiving your vaccination or prescription, these will be ordered at this point and you will be invited for vaccination on arrival of the vaccines. Please be advised that some private vaccinations can take 28 days for the full course to be delivered so early booking is essential prior to travel.**

**5. There are some vaccinations such as Yellow Fever which we do not provide but can be administered at a private travel clinic. Please note that should you require an MMR vaccination that a 4 week gap must be given between the MMR and Yellow fever vaccine. If your timing does not allow for this please liaise with the Practice Nurse about which vaccine should be prioritised.**

**6. Please complete one form for each member of your party**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **VACCINATION HISTORY** | | | | | | |
| Name: DOB:  Address | | | | | | |
| **Previous vaccinations/malaria tablets and dates given:** | | | | | | |
| Tetanus | | Polio | | Diphtheria | | |
| Typhoid | | Hepatitis A | | Hepatitis B | | |
| Meningitis | | Yellow Fever | | Influenza | | |
| Rabies | | Jap B encephalitis | | Tick borne encephalitis | | |
| Other | | | | | | |
| Malaria Tablets | | | | | | |
| PERSONAL DETAILS | | | | | | |
| Name | | | M/F DOB: | | |
| Contact Tel No: | | | | | |
| **Dates of Trip** | | | | | |
| Date of Departure | | | Date of Return | | |
| **Itinerary & Purpose of Visit** | | | | | |
| Country to be Visited | Length of Stay | | Purpose (Tourist/Business) | | Place  (Resort, City, Remote, etc) |
| 1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |
| Any future travel plans: | | | | | |
| **Please tick as appropriate below to best describe your trip** | | | | | |
| |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | **Holiday Type** | Package | | | Cruise | Backpacking | Self-Organised | | Camping | Trekking | | | Cycling | Running | Skiing | | Any planned excursions? | | | | | | | | **Accommodation** | Hotel | | Family/Friends/locals | | Apartment | Tent | | Other (Including staying in hostels/basic accommodation): | | | | | | | | **Travelling** | | Alone | Family/Friends | | Group | Other | | **Area** | | Rural | Altitude | | Forest | Beach | | **Planned activities** | | Safari | Adventure | | Scuba | Healthcare worker | | Visiting family or friends | Pilgrimage | | Medical tourism | Volunteer work | | Business | Expatriate | | Other? | |   **Do you plan to get a tattoo, acupuncture, or any medical or dental work whilst abroad?**  Yes No  **Personal Medical History**   |  |  |  | | --- | --- | --- | |  | **YES** | **NO** | | Do you have any significant medical condition? (including diabetes, heart or lung condition) |  |  | | Are you on any regular medication? |  |  | | Are you allergic to any medication, foods or antibiotics? |  |  | | Do you have epilepsy or a history of fits? |  |  | | Have you ever had a serious reaction to a vaccine? |  |  | | Are you pregnant or breastfeeding? |  |  | | Are you planning pregnancy in the near future? |  |  | | Do you have any history of mental illness including depression or anxiety? |  |  | | Have you recently undergone chemo or radiotherapy or steroid treatment? |  |  | | Have you ever been told you cannot have a “live” vaccine? |  |  | | Does having an injection make you feel faint? |  |  | | Have you ever had a severe reaction to a vaccine before? |  |  | | Do you have any bleeding or clotting disorders? Including a past history of DVT. |  |  | | Please write below any other information you feel may be relevant? |  |  | | | | | | |
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