For details on how to submit form, see end of document

Travel Vaccination 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						
Details about destination(s)						
Country and location to be visited		Length of stay		Away from medical help at destination, if so, how remote?		
1.						
2.						
3.						
Do you plan to travel abroad again in the future?						
Please tick as appropriate below to 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 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 of mental illness including depression or anxiety?
Have you recently undergone radiotherapy, chemotherapy or steroid treatment?
Women only: Are you pregnant or planning pregnancy 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: _____

FOR OFFICIAL USE

Patient Name:

Travel risk assessment performed Yes [ ] No [ ]

Travel vaccines recommended for this trip

Disease protection	Yes	No	Patient declined vaccine	Vaccine name, dose & schedule for PSD
Hepatitis A				
Hepatitis B				
Typhoid				
Cholera				
Tetanus				
Diphtheria				
Polio				
Meningitis ACWY				
Yellow Fever				
Rabies				
Japanese B Encephalitis				
Other				

Travel advice and leaflets given as per travel protocol

Food, water and personal hygiene advice		Travellers' diarrhoea		Blood and bodily fluid infection risks e.g. Hepatitis B	
Insect bite prevention		Animal bites		Accidents	
Insurance		Air Travel		Sun and heat protection	
Websites		SMS vaccines reminder service set up			
Travel record card supplied		Other			

Malaria prevention advice and malaria chemoprophylaxis

Chloroquine and proguanil		Atovaquone + proguanil	
Chloroquine		Mefloquine	
Doxycycline		Malaria advice leaflet given	

Further information

e.g. weight of child

Authorisation for Patient Specific Direction (PSD) Use

Name: _____ Signature: _____ Date: _____

When completed please post this form or hand it in to:

Sleaford Medical Group, 47 Boston Road, Sleaford, NG34 7HD

OR

Submit via the practice website: www.sleafordmedicalgroup.co.uk/medical-forms