**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 **3 days** after returning the form before contacting the surgery to find out the Practice Nurses’ advice and whether you need to make an appointment. **PLEASE ALLOW AT LEAST 8 WEEKS BEFORE YOU TRAVEL AND IDEALLY 12 WEEKS.**

**\*\*** Some vaccinations are only available at a **Private Travel Clinic.** We will inform you when you come in for your routine holiday vaccinations.

**PLEASE NOTE, ONE FORM PER TRAVELLER**

Name: Click or tap here to enter text.

Date of Birth: Click or tap here to enter text.

Address: Click or tap here to enter text.

Tel No: Click or tap here to enter text.

**PLEASE ENCLOSE AN ITINERARY IF POSSIBLE AND BRING ANY RECORD OF VACCINATION WITH YOU TO THE APPOINTMENT.**

**YOUR HEALTH**

Are you pregnant, planning a pregnancy, or breastfeeding? YES  / NO

Which anti-malarial tablets have you taken before? Click or tap here to enter text.

Please specify if you have ever had an adverse reaction to a vaccination or anti-malaria medication YES  / NO

Your weight (if under 45kg)

Have you obtained travel insurance for this trip?

YES  / NO

**Please complete your travel arrangements, including stopovers, in the table below:**

|  |  |  |  |
| --- | --- | --- | --- |
| **COUNTRY** | **AREA/TOWN** | **FROM (DATE)** | **TO (DATE)** |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap to enter a date. | Click or tap to enter a 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

*(Tick as appropriate)*

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

YES  / NO

If so, what? Click or tap here to enter text.

**PATIENT CONSENT**

I confirm the information given on this form is correct to the best of my knowledge, and request advice on immunisation and malaria prophylaxis appropriate to the proposed trip.

Signed: ……………………………………………

Date: Click or tap to enter a date.

***PRACTICE USE ONLY***

**VACCINATIONS REQUIRED**

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

**RECEPTION – CONSULTATION APPOINTMENT REQUIRED AT LEAST 1 WEEK PRIOR TO INJECTION START DATE**

**15 min appt 30 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 |
| **AT LEAST 10 DAYS BEFORE TRAVEL**  \*\*YELLOW FEVER (MMR 4 weeks apart)  MENINGITIS ACWY FLU CHOLERA |
| **AT LEAST 2 WEEKS BEFORE TRAVEL**  1st HEPATITIS A 1st TYPHOID |
| **ANY TIME BEFORE TRAVEL**  DIP, TET & POLIO BOOSTER HEPATITIS A BOOSTER  TYPHOID BOOSTER OTHERS |
| **\*\*MALARIA** C  **P** PC **ME**  DO **MAL** Other identified risks:  Zika Dengue Schistosomiasis  No. DAYS IN MALARIOUS AREA …………… |

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