

TRAVEL IMMUNISATION FORM

Name: _____ DoB _____ Tel no: _____

Date of departure _____ Return or overall length of trip _____

Itinerary and purpose of visit:

Country	Length of stay	How far from medical facilities will you be?

Type of trip: business, pleasure, other

Accommodation: hotel, relatives/family , other

Are you staying in areas which are: urban , rural , high altitude , malarious

Personal medical history

Do you have any allergies? If yes, please specify. Yes No

Have you ever had a serious reaction to a vaccine? Yes No

Do you or any close family members have epilepsy? Yes No

Do you have any history of mental illness including depression, anxiety or eating disorders Yes No

Have you recently undergone radiotherapy, chemotherapy or steroid treatment? Yes No

Have you ever been treated for a thymus disorder? (not thyroid) Yes No

Women only: Are you pregnant, planning pregnancy or breastfeeding? Yes No

Children under 16: Weight: _____

Have you taken out travel insurance? If you have a medical condition have you informed the insurance company about this? Yes No

Please write below any further information which might be relevant.

Please turn over

Vaccination history

Have you ever had any previous vaccinations/malarial tablets and if so, when?

Tetanus _____ Hepatitis A _____ Yellow fever _____

Diphtheria _____ Typhoid _____ Meningitis ACWY _____

Polio _____ Hepatitis B _____ Rabies _____

Anti-malarial _____

Other _____

I have answered the above questions to the best of my knowledge.

Signed: _____ Date: _____

Useful websites: www.nathnac.org www.malariahotspots.co.uk www.fitfortravel.scot.nhs.uk

Please telephone in 3 working days for the results



For official use:

Travel vaccinations recommended for this trip:

Tetanus	<input type="checkbox"/>	Hepatitis A	<input type="checkbox"/>	Yellow fever	<input type="checkbox"/>
Diphtheria	<input type="checkbox"/>	Typhoid	<input type="checkbox"/>	Meningitis ACWY	<input type="checkbox"/>
Polio	<input type="checkbox"/>	Hepatitis B	<input type="checkbox"/>	Rabies	<input type="checkbox"/>

Other

Anti-malarial

Date to commence _____

Signed _____

Date _____