Wight Primary Partnerships Ltd
Travel vaccine request form

This form must be completed at least 6 weeks prior to your estimated travel date

Personal details:

Name:	Date of birth: Male { } Female { }
Easiest contact telephone number: E-mail	

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? YES / NO		

Please tick as appropriate below the best that describes your trip:

Type of Trip						
Visiting area:	Urban		Rural			
Accommodation:	Hotel		Relatives/family home		Camping	
Travelling:	Alone		With family/friend		In a group	
Other:	Cruise Ship		Backpacking		Trekking	

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 or 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.

NB: Please allow two weeks for the Nurse to complete this form before contacting the surgery to check if any vaccinations are required.

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		Jab B Enceph		Tick Borne	
Not sure					

For discussion when risk assessment is performed within your appointment.

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. I have no reason to think that I might be pregnant.

Signed …….. Date ……

FOR OFFICIAL USE:

Patient Name:…… Date of Birth ……..…
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		Travel record card supplied		Sun and heat protection
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 ……