Park View Health Partnership – Travel Form

Please check the inoculations required on www.masta-travel-health.com

THIS FORM MUST BE RETURNED TO RECEPTION AT LEAST 1 WEEK BEFORE YOUR APPOINTMENT

Personal details:

Name:	
Date of Birth:	
Easiest Contact Number:	
Email:	

Dates of Trip:

Date of Departure:	
Return date of overall length of trip:	

Itinerary and purpose of visit:

Country to be visited:	Length of stay:	Away from medical help? If so, how remote
1.		
2.		
Future Travel Plans:		

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?
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 breast feeding?
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 tablet					

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**	**Further Information**
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		Hepatitis B and HIV	
Insect bite prevention		Animal bites		Accidents	
Insurance		Air Travel		Sun and heat protection	
Pill/Pregnancy		Travel Record card supplied		Info on vaccines	
Health brief given		Other:			

Malaria prevention advice and malaria chemoprophylaxis			
Chloroquine and proguanil		Atovaquone + proguanil (Malarone)	
Chloroquine		Mefloquine	
Doxycycline		Malaria advice leaflet given	

Further information
e.g: weight of child

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Signed by: Position: Date: