Brayford Medical Practice
Travel Vaccination Questionnaire

Appointment Date & Time:

(Appointment to be booked when patient presents completed questionnaire.)

All Forms are Treated in the Strictest Confidence
One form per person travelling. Traveller to complete.

Name of Traveller: **Date of Birth:** / /

Travel Itinerary

Date of Departure:	/ /
Destination(s) & Duration of Stay in Each Place:	
Type of Holiday (delete as applicable):	Holiday/Business/VFR/ Other (please state):
Accommodation (delete as applicable):	Hotel/Hostel/Family home/ Other (please state):
ANY High Risk Activities Planned:	(eg. Back packing, snorkelling, safari) Please state:

Medical History

Past/Current Medical History:	Please bring any previous vaccination records with you:
Allergies:	(Food, Drugs, Animals, Plants)
Are you taking steroids:	Yes / No
Do you have HIV:	Yes / No
Are you pregnant:	Yes / No
Are you planning a pregnancy:	Yes / No
Are you taking the contraceptive pill:	Yes / No
Do you have medical insurance arranged:	Yes / No
Have you had ANY previous reactions to any vaccinations:	Yes / No — Please state:

Previous Vaccination History (if known)

Vaccination	Date
Tetanus	
Diphtheria	
Polio	
Typhoid	
Hep A	
Hep B	
Other	

It is recommended that you undertake your own research with regards the vaccinations that may be offered for the destination(s) you are visiting. **Please ensure you visit www.fitfortravel.nhs.uk** before your appointment with the nurse.

All the information given is correct and up to date.

Signed: **Date:** / /

* Please return completed travel vaccination form and make an appointment with the nurse AT LEAST 4 weeks before the date of travel.

* If you decide to have the recommended vaccinations the full fees will be required at the initial consultation.
Your receipt will need to be produced at future vaccination appointments in order for the injection to be administered (fees attached).

* Please ensure you have undertaken your own ressearch with regard vaccinations the nurse is likely to discuss with you.

FOR PRACTICE NURSE USE ONLY:

Vaccine	Tick if Required	BN & Expiry Date	Date Given	Injection Site	Signed
Hep A					
Hep B					
Hep A & B					
Hep A with Typhoid					
Dip/Tet/Polio					
Typhoid					
Meningitis					
Yellow Fever					
MMR					

Name of Prescribing Practitioner:

Date: / /

Signature:

Malaria Tablets:

Tablets	Recommended	Chosen	Number Required
Mefloquine			
Doxycycline			
Atovaquone plus Proguanil			
Chloroquine			
Proguanil			

Child Weight:

Recommended Anti-Malarial Dose:

Additional Comments

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Travel Record Card Given:

Yes / No / Updated

Signed (Practice Nurse):

Date of Review: 8.5.2017