Travel Information Form

This form is an assessment form only. It is important to make your initial appointment with the practice nurse at least 6 weeks before you travel. The initial appointment is to discuss your travel, no vaccinations are given at this appointment.

Please note most travel vaccines have to be ordered as they are not a stock vaccine.

Additionally, some travel vaccines are ordered on a private prescription and these incur a charge. This is because not all travel vaccinations are included in the services provided by the NHS.

Name:	
Date of Birth:	
Contact Tel No:	
Email:	
Preferred method of Contact:	

Travel Details

Date of Travel:	
Countries to be visited and length of stay in each	
1.	
2.	
3.	

Type of accommodation: (eg hotel hostel etc)	
Type of Break: (eg holiday work etc)	
Planned activities (eg skiing, safari etc)	

Medical History

Are you on any medication taken that are NOT prescribed by your GP:	
Have you undergone any recent treatments or admissions to hospital:	
Do you have any allergies or do you have a severe reaction to eggs:	
Are you pregnant or planning a pregnancy:	
Are you using any contraceptives:	

Vaccination Record (record dates of previous vaccines)

Vaccination	Date 1		Date 2		Date 3
Hepatitis A (course of 2 include both dates)		-			
Typhoid					
Hepatitis B (course of 3 include all dates)		-		-	
Diptheria/Tetanus/Polio					
Yellow Fever					
Others		-		-	

DISCLAIMER FORM - STORAGE OF VACCINES

I hereby give written consent to have my vaccines (if any are required) delivered directly from pharmacy and stored in the practice fridges. I understand that if for any reason my vaccines are no longer fit for use i.e the fridges fail and vaccines are stored out with the cold chain policy, the practice will not take responsibility and vaccines will NOT be replaced at the cost of the practice.

****If you do not wish to have your vaccines stored at the practice and wish to collect these from the pharmacy and store at home please do NOT sign below****

Patients Name:_____________________ **Date:**_______________

Patients Signature: ________________________