**Stanley Health Centre**

*FOR ADMIN USE ONLY:*

*Date form received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Is this more than 2 months?* ***YES / NO***

***If NO****, has the patient been advised to contact a Travel Clinic? Add Read Code to Records* ***YES / NO***

*Receptionists Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

***SEND TASK TO PN & PUT FORM IN FOLDER***

**www.stanleyhealthcentre.nhs.uk**

**Travel Vaccination Form**

***We require*** *TWO MONTHS* ***notice to deal with your request***

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Personal details | |  | | |  |
| Name | | Date of birth | | | 🞏 Male  Female |
| Address | | | | | |
| Tele No- Home | | Mobile | | | Work |
| Dates of trip | |  | | |  |
| Departure date | | | Return date or length of trip | | |
| Itinerary and purpose of visit (please add additional countries on separate sheet) | | | | | |
| Country visiting | Length of stay | | | How far away is medical help if none available at destination? | |
| 1 |  | | |  | |
| 2 |  | | |  | |
| Please tick below which best describes your trip | | | | | |
| 1 Type of trip Business Pleasure Other (please state) | | | | | |
| 2 Holiday type Package Camping Self organised  Cruise ship Backpacking Trekking | | | | | |
| 3 Accommodation Hotel Relatives/family Other (please state) | | | | | |
| 4 Travelling Alone With family/friend In a group | | | | | |
| 5 Type of area Urban Rural At altitude | | | | | |
| 6 Planned activities Safari Adventure Other (please state) | | | | | |
| Personal medical history | | | | | |
| Please list any recent or past medical history of note, including diabetes, heart or lung conditions | | | | | |
| Please list any current or repeat medications | | | | | |
| Do you have any allergies – for example to eggs, antibiotics or nuts? Yes (please list) No | | | | | |
| Have you ever had a serious reaction to a vaccine given to you before? Yes No | | | | | |
| Does having and injection make you feel faint? Yes No | | | | | |
| Do you or any close family members have epilepsy? Yes No | | | | | |
| Do you have any history of mental illness, including depression or anxiety? Yes No | | | | | |
| Have you recently undergone radiotherapy, chemotherapy or steroid treatment? Yes No | | | | | |
| Women only: Are you pregnant or planning a pregnancy, or breast feeding? Yes No | | | | | |
| Have you taken out travel insurance, and if you have a medical condition,  Informed the insurance company about this? Yes No | | | | | |
| Please write below any further information that may be relevant. | | | | | |
| |  |  |  | | --- | --- | --- | | Personal details - Vaccination History |  |  | | | | | | |
| |  |  | | --- | --- | | 🞏 Tetanus Date: | 🞏 Hepatitis A (single vaccination) Date: | | 🞏 Typhoid Date: | 🞏 Hepatits A (booster) Date: | | 🞏 Meningitis Date: | 🞏 Hepatitis B (course of 3) Date: | | 🞏 Rabies Date: | 🞏 Japanese encephalitis Date: | | 🞏 Polio Date: | 🞏 Tick borne encephalitis Date: | | 🞏 Diptheria Date: | 🞏 Influenza Date: | | 🞏 Yellow Fever Date: | 🞏 Malaria tablets Date: | | 🞏 Other (state) |  | | | | | | |
|  | | | | | |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | | |  | | |  |
| FOR OFFICIAL USE ONLY | | | | |  | | |  |
| Travel risk assessment done 🞏Yes 🞏No | | | | Vaccinations to commence on or before: | | | | |
| Travel vaccines recommended for this trip (plus any further information) | | | | | | | | |
| 🞏 Hepatitis A | | | | | | | | |
| 🞏 Hepatitis B | | | | | | | | |
| 🞏 Typhoid | | | | | | | | |
| 🞏 Cholera | | | | | | | | |
| 🞏 Tetanus | | | | | | | | |
| 🞏 Diptheria | | | | | | | | |
| 🞏 Polio | | | | | | | | |
| 🞏 Meningitis ACWY | | | | | | | | |
| 🞏 Yellow Fever | | | | | | | | |
| 🞏 Rabies | | | | | | | | |
| 🞏 Japanese Encephalitis | | | | | | | | |
| 🞏 Tick borne encephalitis | | | | | | | | |
| Travel advice and leaflets as per protocol | | | | | | | | |
| 🞏 Food, water and personal hygiene advice | | | 🞏 Traveller’s diarrhoea | | | | 🞏 Hepatitis B and HIV | |
| 🞏 Insect bite prevention | | | 🞏 Animal bites | | | | 🞏 Accidents | |
| 🞏 Insurance | | | 🞏 Air travel | | | | 🞏 Sun and heat protection | |
| 🞏 Websites | | | 🞏 Travel record supplied | | | | 🞏 Other | |
| Malaria prevention advice and malaria chemoprophylaxis | | | | | | | | |
| 🞏 Chloroquine and proguanil | | 🞏 Chloroquine | | | | 🞏 Mefloquinine | | |
| 🞏 Atovaquone + proguanil (Malarone) | | 🞏 Doxycline | | | | 🞏 Malaria advice leaflet | | |
| Further information | | | | | | | | |
| Eg: weight of child | | | | | | | | |
| STAFF USE ONLY - Authorisation | | | | | | | | |
| Signed by: | Position: | | | | | Date: | | |
| **For discussion when assessing risk during your appointment:**  **I have no reason the think that I might be pregnant. I have received information on the risks and benefits of the vaccinations recommended and have had the opportunity to ask questions.**  **I consent to the vaccines being given.**  **Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | |

***Practice Nurse Notes:***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_