**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 |  |  |

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|

|  |  |
| --- | --- |
| 🞏 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) |  |

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|  |

|  |  |  |
| --- | --- | --- |
|  |  |  |
| 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:***

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