RECTORY MEADOW SURGERY
TRAVEL RISK ASSESSMENT FORM

Patient's Personal Details

Full Name: Date of Birth: Age: Male/Female

Dates of Trip

Date of departure: Return date (or length of trip):

Itinerary and Purpose of Visit Type of Trip: Accommodation Away from medical help at destination?

Country(s) to be visited: Business / Pleasure / Other Type:

If so, how remote?

Do you have any recent or past medical history of note? (including diabetes, heart or lung conditions)?	Yes / No
Are you on any regular medication?	Yes / No
Do you have any allergies, for example to eggs, antibiotics, nuts?	Yes / No
Have you ever had a serious reaction to a vaccine given to you before?	Yes / No
Does having an injection make you feel faint?	Yes / No
Do you or any close family members have epilepsy?	Yes / No
Do you have any history or mental illness including depression or anxiety?	Yes / No
Have you recently undergone radiotherapy, chemotherapy or steroid treatment?	Yes / No
Have you taken out travel insurance and if you have a medical condition, informed the insurance company about this?	Yes / No
Women only: Are you pregnant or planning pregnancy or breastfeeding?	Yes / No
Please write below any further information which may be relevant:	

Travel vaccines recommended for this trip (to be completed by Practice Nurse)

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		Hep 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		Atovaquoe + proguanil (Malarone)		Chloroquine	
Mefloquine		Doxycycline		Malaria advice leaflet given	

Further information: eg weight of child

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.

Patient's Signature: _____ Date: _____

For Rectory Meadow Surgery: Travel risk assessment performed Yes / No

Signature: _____ Position: _Practice Nurse __ Date: _____

I authorise administration of the above highlighted vaccine(s) to be given to the above named patient in accordance with Rectory Meadow Surgery **Patient Specific Directives**

GP signature: _____ Date: _____