Torkard Hill Medical Centre
Travel Vaccination Questionnaire

Date form received:

One form per person travelling. Traveller to complete.

Name of Traveller:

Date of Birth:

Contact Number:

Travel Itinerary

Date of Departure:	
Destinations(s) & duration of stay in each place:	
Type of Holiday (delete as applicable):	Holiday / Businesss /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:	
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 pregnancy:	Yes / No
Are you taking the contraceptive pill:	Yes / No
Have you had ANY previous reactions to any vaccinations:	Yes / No

Previous Vaccination Hisotry (if known)

Vaccination	Date
Tetanus	
Diptheria	
Polio	
Typhoid	
Hep A	
Hep B	
Other	

All the information given is correct and up to date:

Signed:

Date:

Please note:

*Please return the completed form to the surgery at least 6 weeks before your departure date and the nurse will contact you to arrange an appointment.

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					

Name of Prescribing Practitioner:

Date:

Signature:

Malaria Tablets:

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

Child Weight:

Recommended Anit-Malarial Dose:

Additional Comments:

Travel Record Card Given:

Yes / No / Updated

Signed (Practice Nurse):

Appointment Date & Time:

Appointment with: