

BLACKTHORN HEALTH CENTRE PRE-TRAVEL VACCINATION ASSESSMENT

PLEASE COMPLETE THIS FORM AND HAND IT TO THE PRACTICE NURSE WHEN YOU ATTEND YOUR FIRST TRAVEL APPOINTMENT (allow at least 2 weeks before travel)

NAME List Allergies.....
.....

D.O.B
.....

ADDRESS List medication.....
.....

TEL No.

EMAIL Do you or have you suffered with
Heart Disease or other Chronic illness

Date of travel
.....

Duration of stay abroad.....
.....

Which countries do you intend to visit ?
(including stopovers)
.....
.....

Are childhood vaccinations up to date
Including Polio,Diphtheria, Tetanus?
Dates if known

Have you ever had any of the
following vaccinations. If so When?

TYPHOID Y/N.....

HEPATITIS A Y/N.....

HEPATITIS B Y/N.....

HEPATITIS A+B Y/N.....

YELLOW FEVER Y/N.....

Give details of accommodation ie hotel
Tent, relatives accommodation
.....
.....

Does your journey include;
Coastal area yes/no
Inland/border yes/no
Islands yes/no
Cruise yes/no

NOTES FOR PRACTICE NURSE

VACCINES REQUIRED

.....
.....
.....

MALARIA PROPHYLAXIS

.....

Do you plan any Safaris, jungle
Or Travel in difficult terrain with little or
No medical help? Give details
.....
.....

Have you had your spleen removed?
Yes/no
Is your travel for business, work or leisure?
.....