### TRAVEL VACCINE REQUEST FORM

PLEASE COMPLETE ONE FORM FOR EACH PERSON TRAVELLING.

THE INFORMATION REGARDING THE VACCINATIONS THAT ARE APPROPRIATE, SHOULD BE AVAILABLE 5 WORKING DAYS AFTER YOU HAVE HANDED THIS FORM IN. PLEASE CONTACT RECEPTION AFTER THIS TIME, THE NECESSARY APPOINTMENTS CAN THEN BE MADE FOR YOUR VACCINATIONS.

NAME……………………………………………DOB………………………CONTACT PHONE NUMBER………………………………….

HAVE YOU ARRANGED MEDICAL INSURANCE? YES/NO

HAVE YOU A REACTION TO A PREVIOUS VACCINATION? YES/NO

DO YOU FEEL FAINT WITH INJECTIONS? YES/NO

MEDICAL HISTORY

……………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

ALLERGIES (MEDICATION/FOOD/OTHER)

…………………………………………………………………………………………………………………………………..

CURRENT MEDICATION(S)

………………………………………………………………………………………………………………………………………………………………………………………………………………………………

DO YOU TAKE THE

CONTRACEPTIVE PILL? YES/NO

DO YOU TAKE STEROIDS? YES/NO

ARE YOU PREGNANT? YES/NO

ARE YOU PLANNING TO

BECOME PREGNANT? YES/NO

TRAVEL ITINERY

DATE OF DEPARTURE…………………….

DESTINATION(S) & LENGTH OF STAY FOR EACH ONE

……………………………………………………………

…………………………………………………………..

…………………………………………………………..

TYPE OF TRAVEL

HOLIDAY/BUSINESS/BACK PACKING/

VISITING FRIENDS OR RELATIVES

ACCOMODATION

HOTEL/HOSTEL/SELF CATERING/OTHER …………………………………………………………..

HIGH RISK ACTIVITIES (EG:DIVING/CLIMBING/TREKKING)

…………………………………………………….

VACCINATION HISTORY

|  |  |  |  |
| --- | --- | --- | --- |
| INJECTION | DATE GIVEN | INJECTION | DATE GIVEN |
| TETANUS |  | HEPATITIS A |  |
| DIPTHERIA |  | HEPATITIS B |  |
| POLIO |  | MENINGITIS |  |
| TYPHOID |  | YELLOW FEVER |  |
| OTHER |  |  |

THE INFORMATION PROVIDED IS CORRECT AND I AM WILLING TO ACCEPT THE TRAVEL VACCINATION ADVICE GIVEN TO ME IN RELATION TO THIS INFORMATION

SIGNED…………………………………………………………… DATE……………………………………..