**Aylmer Lodge Cookley Partnership**

**Travel Risk Assessment Form**

**Instructions**

1. Fill in one form for each traveller.
2. Complete form with as much information about your previous vaccinations and travel destination/itinerary as possible.

|  |
| --- |
| **Personal details** |
| Name: | D.O.B: |
| Address: |
| Tel No: |

|  |  |  |
| --- | --- | --- |
| **Specific countries to be visited** | **Date of departure** |  **Length of stay** |
| 1. |  |  |
| 2. |  |  |
| 3. |  |  |

|  |
| --- |
| **Please tick as appropriate below to best describe your trip** |
| 1.Type of trip | Business | Pleasure | Other |
| 2. Holiday Type | Package | Self-organised | Backpacking |
| Camping | Cruise Ship | Trekking |
| 3. Accomodation | Hotel | Relatives/family home | Other |
| 4.Travelling | Alone | With family/friend | In a group |
| 5.Staying in area which is | Urban  | Rural |  |
| 6.Planned Activities | Safari | Adventure | Other |

|  |
| --- |
| Will you be away from medical help at your destination, if so for how long and how remote? |

|  |
| --- |
| **Personal medical history** |
| Do you have any recent or past medical history of note? (Including diabetes, heart or lung conditions) |
| List any current or repeat medications: |
| Do you have allergies for example to eggs, antibiotics, nuts? |
| Have you ever had a serious reaction to a vaccine given to you before? |
| Does having injections make you feel faint? |
| Do you or any close family members have epilepsy? |
| Do you have a history of mental illness including depression or anxiety? |
| Have you recently undergone radiotherapy, chemotherapy or steroid treatment? |
| *Women only:* Are you pregnant or planning pregnancy or breastfeeding? |
| Have you taken out travel insurance and if you have a medical condition, informed the insurance company about this? |
| Please write below any further information which may be relevant |

|  |
| --- |
| **Vaccination history** Have you ever had any of the following vaccinations/malaria tablets and if so when? |
| Tetanus |  | Polio |  | Diphtheria |  | Other, Please State |  |
| Typhoid |  | Hepatitis A |  | Hepatitis B |  |  |  |
| Meningitis |  | Yellow Fever |  | Influenza |  |  |  |
| Rabies |  | Jap B Enceph |  | Tick Bourne |  | Malaria Tablets |  |
| I confirm the above information to be correct to the best of my knowledgeSigned (Parent if under 16yrs) Date |

**FOR OFFICIAL USE**

|  |  |
| --- | --- |
| **Travel Vaccines recommended for this trip** |  |
| Disease protection | Yes | Confirmed | Required | Vaccine Given | Batch Number  | Date |
| Hepatitis A |  |  |  |  |  |  |
| Hepatitis B |  |  |  |  |  |  |
| Typhoid |  |  |  |  |  |  |
| Cholera |  |  |  |  |  |  |
| Tetanus |  |  |  |  |  |  |
| Diphtheria |  |  |  |  |  |  |
| Polio |  |  |  |  |  |  |
| Meningitis ACWY |  |  |  |  |  |  |
| Yellow Fever |  |  |  |  |  |  |
| Rabies |  |  |  |  |  |  |
| Japanes B Encephalitis |  |  |  |  |  |  |
| Other |  |  |  |  |  |  |

|  |
| --- |
| **Travel Advice and leaflets given** |
| Food water and personal hygiene advice | Travellers’ diarrhoea  | Hepatitis B and HIV |
| Insect Prevention | Animal Bites | Accidents |
| Insurance | Air Travel | Sun and heat protection |
| Other |  |  |

|  |
| --- |
| **Malaria Prevention advice and malaria chemoprophylaxis**Malaria Chemoprophylaxis required: Weight (Child) |

|  |
| --- |
| I have no reason to think I might be pregnant. 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 givenSigned (Parent if under 16yrs) Date |

|  |
| --- |
| The patient named above can be given \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ vaccination by subcutaneous or intramuscular injectionBy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (nurse)Authorised by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Doctor or independent prescriber) |

|  |
| --- |
| Vaccination given Signed by : Position Date |