Skene Medical Group

Admin only
Date form received:-

Travel Risk Assessment Form

Forms should be completed and returned to reception **6 – 8 weeks prior to travel departure date** (forms submitted with short notice may be asked to contact private travel clinic).

Please complete both sides/ pages of the form.

Name: **Date of Birth :** **Age:** **Weight** (for children under age 12)**:**		
Address: (incl post code)	**Easiest contact telephone no:** **Email:**	
Date of travel: Departure:	Return:	
Itinerary: 1. Country/name area(s) town/resort?		
2. Length of stay?		
3. Away from medical help at destination?		
Please circle the descriptions that best describe your trip		
1. **Type of trip:**	Pleasure	Occupational Contact work OH service
2. **Holiday type:**		
Package	Self-organised	Backpacking
Camping	Cruise ship	Trekking
Volunteer work – give details:		
3. **Accommodation:**		
Hotel	Relatives/family home	Other give details
4. **Travelling**:		
Alone	With family/friend	In a group
5. **Staying in area which is:**		
Urban	Rural	Altitude
6. **Planned activities:**		
Safari	Adventure	Other/specify
Personal medical history Do you have any recent or past medical history of note? This includes diabetes, heart or lung conditions, thyroid disorder.		

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List any current or repeat medications.

Do you have any 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/phobia?

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 breast feeding?

Have you taken out travel insurance? If you have a medical condition, have you informed the insurance company about this?

Please give any further information that may be relevant, including any further travel plans.

Vaccination history

Have you ever had any of the following vaccinations, and if so when?

Tetanus	[ ]	Polio	[ ]	Diphtheria	[ ]
Typhoid	[ ]	Hepatitis A	[ ]	Hepatitis B	[ ]
Meningitis	[ ]	Yellow fever	[ ]	Influenza	[ ]
Rabies	[ ]	Jap B enceph	[ ]	Tick borne	[ ]

Other vaccines given outwith GP practice?

Malaria tablets taken previously?

Any previous problems / adverse reactions :

For Patient signature following assessment and before immunisation:

I have no reason to think that 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 / do not consent to the recommended vaccines being given.

Signed : Date