

APPOINTMENT DATE: _____ NURSE: _____

NAME: _____ D.O.B. / / _____ Male/Female*
CONTACT TELEPHONE NUMBER(s): _____

TRAVEL ITINERY
Date of Departure: _____
Destination(s) and duration of stay:

TYPE OF HOLIDAY:
Holiday/Business/Visiting Friends or Relatives/other*
Accommodation:
Hotel (__ Star) / Hostel / Family Home*
High Risk Activities: (Please give details)

Medical Insurance Arranged? YES/NO*

CURRENT HEALTH PROBLEMS
Please give details:

MEDICATION: Including Oral Contraceptive

ALLERGIES:

Are you Pregnant? YES/NO*
Is Pregnancy Planned: YES/NO*

PREVIOUS VACCINATION HISTORY
If Known:

Tetanus	YES/NO*
Diphtheria	YES/NO*
Polio	YES/NO*
Typhoid	YES/NO*
Hepatitis A - First/ Booster*	YES/NO*
Hepatitis B	YES/NO*
Meningitis	YES/NO*
Yellow Fever	YES/NO*
Other	YES/NO*
Any previous reaction to vaccines?	YES/NO*

FOR OFFICE USE ONLY
RECOMMENDED VACCINES:

TETANUS/DIPHTHERIA/POLIO	<input type="checkbox"/>
TYPHOID	<input type="checkbox"/>
HEP A	<input type="checkbox"/>
HEP B	<input type="checkbox"/>
MENINGITIS	<input type="checkbox"/>
MMR	<input type="checkbox"/>
YELLOW FEVER	<input type="checkbox"/>
RABIES	<input type="checkbox"/>
JAP. B. ENCEPHALITIS	<input type="checkbox"/>
MALARIA	<input type="checkbox"/>

COST OF VACCINE (Inc. postage & VAT + Admin Fee)
£ _____ PATIENT INFORMED
DATE PAID: _____
ORDER DATE: _____

PATIENT DECLARATION * Delete as necessary

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 to the vaccines being given.

SIGNED: _____ DATE: _____