THE GROBY SURGERY

TRAVEL VACCINATION – INFORMATION COLLECTION SHEET

Personal details			
Name:		Date of birth:	Male { } Female { }
Easiest contact telephone number:			
Dates of trip			
Date of departure		Return date or overall length of trip	
Details about destination(s)			
Country and location to be visited	Length of stay	Away from medical help at destination, if so, how remote?	
1.			
2.			
3.			

Please tick as appropriate below to best describe your trip			
Holiday type	Package	Cruise Ship	Back-Packing
		Family Home	

Personal medical history			
Do you have any recent or past medical history of note? (including diabetes, heart or lung conditions)			
Do you have any allergies e.g. eggs, antibiotics, nuts or latex?	**YES/NO**	Have you ever had a serious reaction to a vaccine given to you before?	**YES/NO**
Does having an injection make you feel faint?	**YES/NO**	Do you or any close family members have epilepsy?	**YES/NO**
Do you have any history of mental illness including depression/anxiety?	**YES/NO**	Have you recently undergone radiotherapy, chemotherapy or steroid treatment?	**YES/NO**
Women only: Are you pregnant or planning pregnancy or breastfeeding?	**YES/NO**	Have you taken out insurance and if you have a medical condition, informed the insurance company about this?	**YES/NO**
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	
Typhoid		Hepatitis A		Hepatitis B	
Meningitis		Yellow Fever		Influenza	
Rabies		Jap B Enceph		Tick Borne	
Other					
Malaria tablets are available at Asda pharmacy without private prescription					

For discussion when risk assessment is performed within your appointment.

PLEASE BE ADVISED THAT OUR TRAVEL VACCINATION FORMS WILL BE SUBMITTED TO ONE OF OUR NURSES ON THE DAY. THIS WILL BE REVIEW BY THEM WITHIN **3-5 WORKING DAYS** AND ALL RESULTS WILL BE NOTED ON THE PATIENTS RECORD.

PLEASE BE ADVISED THAT IT IS PATIENT'S RESPONSIBILITY TO SUBMIT THESE FORMS INTO THE SURGERY AT LEAST **6 WEEKS** PRIOR TO TRAVELLING AND TO CONTACT THE SURGERY AFTER **5 DAYS** TO CHECK THE OUTCOME. OUR NURSES **WILL NOT** CONTACT PATIENTS.

OFFICE USE ONLY:

Receptionist receiving form: _____ Date: _____

Staff completing form: _____ Date: _____