PRE-TRAVEL HEALTH & VACCINATION ASSESSMENT

Name: _____

Address: _____

Contact telephone no.: _____

Date of Birth: _____

Destination(s): _____

Date of Departure: _____ Length of stay: _____

Type of Accommodation(i.e. tourist hotels, relatives homes,basic local accommodation)

_____

Any past or current medical conditions/illness:

_____

_____

Medications(e.g. contraceptives,steroids, Immunosuppressants: _____

_____

PTO

Chemo/radiotherapy within the last 6 months: _____

Pregnant/planning pregnancy/breast feeding _____

Previous bad reaction to a vaccine or other allergies; (e.g. eggs) _____

Dates of any previous vaccinations: _____

_____

_____

To be completed by the nurse prior to appointment

Vaccines needed: _____

_____

_____

_____

_____

Malaria prophylaxis advice: _____

Printed information given: _____

Signature of Nurse: _____