

TRAVEL CLINIC SCHEDULE (Please see read the patient information sheet before completing the schedule)

You may need travel vaccinations depending on the country you intend to visit. In order to provide this advice, please complete this form and return it to Reception as soon as possible prior to travel. You **should allow at least 6 weeks prior to travel**. You should contact us 14 days from the date you hand in the completed schedule PLEASE NOTE WE DO NOT CONTACT YOU! A Travel Pack will be available for you to collect within 14 days detailing vaccinations required and Travel Health information. Private prescription charges will need to be paid when you collect the Travel Pack.
Information on Travel Health and Travel Vaccinations can be found at www.fitfortravel.nhs.uk.

Completion Date:..... Name: Date of Birth:

Tel No: Home:..... Work:..... Mobile:..... Doctor's Name:.....

Which countries, in sequence do you intend to visit? Include stop overs, however brief and be specific about areas you are visiting:

Type of Trip (please tick):

- Package Holiday Emigration/long stay Backpacking/self organised trip Elective student
 Cruise Business more than 3 months Voluntary/Charity work
 Organised adventure holiday Business less than 3 months visiting family/friends

Occupation abroad, if relevant: Will you be visiting:- Coastal area Rural area Area over 3000m

Do you plan any safaris, jungle exploration or travel in difficult terrain? *YES / NO If yes details:.....

Departure Date: Length of stay:..... Accommodation type: Camping Hostels Hotel Private Home

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

Vaccination	Date	Vaccination	Date	Vaccination	Date
BCG		Tetanus		Diphtheria	
Polio		Hepatitis A		Hepatitis B	
Typhoid		Yellow Fever		Rabies	
Jap B encephalitis		Meningococcal		Tick borne encephalitis	
Cholera		Yellow Fever			

Are you allergic to anything: *YES / NO If yes details:

Do you have any medical problems *YES / NO If yes details:

Please list your Regular Medications:

Are you pregnant or breast feeding *YES / NO Please detail any mental health problems :

I confirm I have read the above and agree with my answers and I request vaccinations Signature: * Self / parent / guardian

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Vaccinations Already Recorded		Vaccinations Required				Comments e.g Private Prescription/NHS Prescription
Vaccination	Date Given	1 st Dose	2 nd Dose	3 rd Dose	Booster	
BCG						
Tetanus						
Diphtheria						
Polio						
Hepatitis A						
Hepatitis B						
Jap B encephalitis *						
Measles						
Meningococcal *						
Rabies *						
Swine flu						
Tick borne encephalitis *						
Typhoid						
Yellow Fever *						
Cholera						Not routinely recommended for travel
Malaria Prophylaxis						

Chloroquine(pharmacy) Proguanil(pharmacy) Doxycycline* Mefloquine* Malarone*

Avloclor (pharmacy) Paludrine (pharmacy) Other

*** Private Prescription**

Documents / Information Given to Patients:

- Travel Vaccination Prescription *NHS / PRIVATE / BOTH
- Anti-malarial details
- TRAVAX information Sheet
- Yellow Fever Recommendation (we are not a registered yellow fever clinic)
- General Information Sheets
- Details of Charges attached to outside of envelope for patient Total Charge: £_____

Signature of Health professional completing vaccine schedule: Date Schedule completed:

Doctor's Signature: (as authorisation to administer) Date:

Vaccines detailed above administered by: Name: Signature: Date.....

FOR RECEPTIONIST/OFFICE USE ONLY

Date Schedule Issued to Patient: _____ **Intls** _____ **Date Completed Schedule Received from Patient** _____ **Intls** _____