

## HEADLANDS SURGERY

### FOREIGN TRAVEL VACCINATIONS AND IMMUNISATION

**For travellers departing in 4 weeks or less you are advised to make alternative arrangements, as we are unable to process ANY applications at such short notice.  
THIS APPLICATION WILL TAKE 4 WORKING DAYS TO PROCESS**

Please complete this form for each person travelling and return it ***at least six weeks*** prior to travel. This enables the Practice Nurse to process your travel requirements.

Name:..... Date of Birth:.....  
 Address:..... Daytime Phone No:.....  
 ..... Child Age & Weight:.....

Countries to be visited, including stopovers	Dates		Types of holiday (business, pleasure, family) inc. accommodation
	From	To	

#### **PERSONAL & MEDICAL HISTORY (inc. any current illness)**

	Yes	No
Heart & Lung		
Asthma		
Diabetes		
Epilepsy		
Undergoing Chemo- or Radiotherapy		
Removal of Spleen		
Pregnancy/Breast –feeding or trying to become pregnant		
Have you reacted badly to any previous vaccine? If YES please give details.		
Have you any severe allergies (e.g. eggs, nuts, antibiotics)? If YES please give details.		
Do you have any other current medical problems? If YES please give details.		
Insurance		

Form received by (Name) .....

Form returned on (Date) .....

Patient advised to ring on (Date) .....

**FOR NURSE USE ONLY**

Patient's Name:.....Date of Birth:.....Date of Appointment: .....

**VACCINATIONS AND IMMUNISATION SCHEDULE**

<b>Vaccinations/Immunisations Needed</b>	<b>Date of last known injection</b>	<b>Advice Given</b>
Hepatitis A		
Hepatitis B		
Diphtheria, Tetanus, Polio		
Typhoid		
Rabies		
Meningococcal ACWY		
Yellow Fever		
Japanese Encephalitis		
MMR		
Cholera		
Other		

**Review/Discuss/Written Information**

	<b>Discussed</b>	<b>Written Information</b>
Traveller's Diarrhoea		
Insect Repellent		
Malaria Prophylaxis		
Sun screen		

**Malaria Medication**

<b>Choice</b>	<b>Amount of Tablets</b>	<b>Travax Advice Sheet</b>
Chloroquine		
Proquanil		
Malarone		
Doxycycline		
Mefloquine		

**Patient Consent**

**Signature:..... Date:.....**

**FOR RECEPTION ONLY**

COUNTRY ..... DATE OF DEPARTURE.....

Patient's Name:.....Date of Birth:.....Date of Appointment: .....

Information given to patient by:.....on.....

Forward for scanning

<b>Information only</b>	Yes	No
<b>Vaccinations Needed</b>		
Hepatitis A	No charge	
Diphtheria, Tetanus & Polio	No charge	
Typhoid	No charge	
MMR	No charge	
Hepatitis B	To pay	
Meningitis ACWY	To pay	
Japanese Encephalitis	To pay	
Rabies	To pay	
Ticke-borne Encephalitis	To pay	
Yellow Fever (at a designated centre)	To pay	
Cholera	NHS Prescription	
<b>Antimalarials</b>		
<b>Other</b>		
<b>Appointment Needed (20 minutes for first consultation)</b>		