TRAVEL IMMUNISATION FORM

DATE RECEIVED _____ (admin use only)

PART A TO BE COMPLETED BY PATIENT

To be answered by, or on behaf of, the person to be immunised.
Please hand in completed form to reception at least 4 weeks before outward travel date.
Please allow 4 working days before phoning the surgery to book an appointment.

NAME _____ DATE OF BIRTH _____

ADDRESS _____

_____

_____

_____

TEL NUMBER _____ GP _____

Are you unwell at present YES [ ] NO [ ]

Have you any continuous illness for which you see a doctor, or take treatment.

_____

_____

Are you having, or have you had, Steroids eg. Prednisolone

_____

_____

Could you be pregnant [Y / N]

Are you HIV (or immune suppressed, as some vaccines may not be suitable)

_____

_____

Have you received deep x-ray or radium treatment

_____

_____

Are you allergic or sensitive to :

[Y / N]	Penicillan	[Y / N]	Neomycin
[Y / N]	Streptomycin	[Y / N]	Polymycin
[Y / N]	Eggs		

Have you or any members of your family not had their full course of polio immunisations.

_____

_____

Have you had any injections in the last three weeks

_____

_____

Have you had any problems/reactions with injections in the past

_____

_____

Have you ever had Epilepsy or Mental Health problems including depression
(some Malaria tablets may not be suitable)

_____

Which countries/regions will you visit or pass through, please state length of stay in each country.

Date of travel _____ _____

Please specify type of travel:

☐	Staying in a hotel	☐	Staying with relatives	☐	Camping
☐	Aide worker	☐	Kibbutz	☐	Other

Are you a frequent traveller(number of times per year / areas visited)

I have completed the above to the best of my knowledge

SIGNATURE OF PATIENT _____ DATE _____
(parent or guardian if under 18 years)

PART B TO BE COMPLETED BY PRACTICE NURSE

	Y / N	£		Y / N	£
HEP A COURSE/BOOSTER			HEP A & TYPHOID		
HEP B COURSE/BOOSTER			REVAXIS (DTP)		
MEN ACWY			CERTIFICATE		£15.00
MALARIA TABLETS			MALARIA PRESCRIPTION		£15.00

TOTAL COST £ _____

PART C TO BE COMPLETED BY APPROVING DOCTOR

SIGNATURE _____ DATE _____

TRAVEL VACCINE COSTS

SOME VACCINES ARE PROVIDED FREE OF CHARGE, AS DETERMINED BY THE D.O.H. THESE ARE REVIEWED REGULARLY AND ARE SUBJECT TO CHANGE DEPENDING ON WORLD HEALTH EVENTS. THE COSTS PAYABLE BY YOU ARE DETAILED ABOVE, THESE FEES ONLY APPLY TO PATIENTS REGISTERED AT CARRINGTON HOUSE SURGERY.

CHARGES WILL BE APPLIED FOR NON REGISTERED PATIENTS, PLEASE ASK FOR PRICE LIST.

PAYMENT MUST BE MADE AT TIME OF IMMUNISATION. CHEQUE OR CASH ONLY.

PART D TO BE COMPLETED BY PATIENT AT APPOINTMENT WITH PRACTICE NURSE

The above has been explained to me and I agree to the recommendations as above. I understand that no vaccine offers 100% protection, and a small proportion of individuals get infected despite vaccination. I also understand the risks if I do not receive the full recommended dose schedule for any vaccinations required.

SIGNATURE OF PATIENT _____ DATE _____

(parent or guardian if under 18 years)