Parkfield Medical Centre

IMMUNISATIONS FOR FOREIGN TRAVEL

Fill in one form for EACH traveller **Date_____**

SURNAME_____FIRST NAMES_____

Address_____TEL NO._____

_____

_____

Which country(ies) are you visiting?

When do you leave?

How long are you staying?

Are you stopping anywhere on the journey YES/NO
e.g. to change flights

If YES, where and for how long hours day weeks

Are you staying in a hotel or private home?

Will you camp or visit rural areas?

Have you been immunised previously against…..

TETANUS	**YES/NO**	**when?**	**_____year**
POLIO	**YES/NO**	**when?**	**_____year**
TYPHOID	**YES/NO**	**when?**	**_____year**
MENINGITIS	**YES/NO**	**when?**	**_____year**
YELLOW FEVER	**YES/NO**	**when?**	**_____year**
RABIES	**YES/NO**	**when?**	**_____year**
HEPATITIS A	**YES/NO**	**when?**	**_____year**
HEPATITIS B	**YES/NO**	**when?**	**_____year**
ENCEPHALITIS	**YES/NO**	**when?**	**_____year**
Others eg RUBELLA	**YES/NO**	**when?**	**_____year**

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Do you have any medical problem requiring regular supervision? YES/NO

If YES, what is the problem?
_____

Are you taking steroids? YES/NO

Have you ever suffered from convulsions or depression? YES/NO

Are you taking any other regular medication including the oral contractive pill? YES/NO

If YES, what are you taking?_____

Are you pregnant? YES/NO

Have you reacted badly to any previous vaccine? YES/NO

If YES, which vaccine?_____

Are you allergic to any medicines/or have an egg allergy? YES/NO

If YES, which?_____

I confirm the above answers to be correct to the best of my knowledge and request immunisations as appropriate to my trip.

PATIENT'S SIGNATURE_____Date_____

Vaccination Schedule

Vaccination	Date due	Remarks