Alma Partnership Travel Vaccination Form

Admin only	
Date in:	Date to doctor:
Doctor/Nurse only	
Vaccines required:	
Cost to patient:	£
Appointment required within:	

Personal Details			
Name:		Sex:	
Date of Birth:			
Daytime telephone no.		Email:	
Address			
Postcode			

Trip dates			
Departure Date:		Duration of trip:	

Itinerary and Purpose of Visit		
Country	Duration of stay	Availability of medical help

Trip Description – please tick all appropriate boxes	
Purpose of trip:	☐ Business ☐ Pleasure ☐ Other
Type of trip:	☐ Package ☐ Self-organised ☐ Backpacking ☐ Camping ☐ Cruise Ship ☐ Trekking
Accommodation:	☐ Hotel ☐ Friends/family ☐ Other
Travelling:	☐ Alone ☐ With friends/family ☐ In a Group
Location type:	☐ Urban ☐ Rural ☐ Altitude
Activity type:	☐ Safari ☐ Adventure ☐ Other

Please turn over…….

Personal Medical History	
List below all chronic medical conditions that you have (e.g. diabetes, heart or lung conditions)	
List below all allergies that you have (e.g. eggs, nuts, antibiotics)	
If you have had a serious reaction to a vaccine in the past, which vaccine was it?	
List below all of your current medications (including oral contraception)	
Have you recently suffered from any infection (e.g. heavy cold, flu or high temperature)?	☐ Yes ☐ No
Does having an injection cause you to feel faint?	☐ Yes ☐ No
Do you or any close family members have epilepsy?	☐ Yes ☐ No
Do you have a history of mental illness including depression or anxiety?	☐ Yes ☐ No
Have you taken out travel insurance?	☐ Yes ☐ No
If you have a medical condition, have you told your insurance company about it?	☐ Yes ☐ No
Are you pregnant or breast feeding?	☐ Yes ☐ No
Write below any further information that may be relevant (continue on a separate sheet if necessary)	

Vaccination History			
Have you ever had any of the following vaccinations/tablets and if so, when?			
Tetanus	☐ Yes Date:	Polio	☐ Yes Date:
Diptheria	☐ Yes Date:	Typhoid	☐ Yes Date:
Hepatitis A	☐ Yes Date:	Hepatitis B	☐ Yes Date:
Meningitis	☐ Yes Date:	Yellow Fever	☐ Yes Date:
Influenza	☐ Yes Date:	Rabies	☐ Yes Date:
Jab B Enceph	☐ Yes Date:	Tick Borne	☐ Yes Date:
Malaria Tablets	☐ Yes Date:	Other	☐ Yes Date:

Patient consent

I confirm that I have completed the questionnaire to the best of my knowledge and request vaccination and advice appropriate to my trip

Signed:_____(adult with parental responsibility for person under 16)

Date:_____