Burnham Health Centre
Minniecroft Road, Burnham, Buckinghamshire SL1 7DE

Tel: 01628 666326 Fax: 01628 663743

PRE-TRAVEL HEALTH & VACCINATION ASSESSMENT

Date Form Completed:		
Surname:		Forename:
Date of Birth:	Contact number:	Male ☐ Female ☐

PLEASE SUPPLY INFORMATION ABOUT YOUR TRIP IN THE SECTIONS BELOW

Date of departure:	Total length of trip:

COUNTRY TO BE VISITED	EXACT LOCATION OR REGION	CITY OR RURAL	LENGTH OF STAY	Will your journey take you to the:		
				COAST	INTERIOR	ISLANDS
1.						
2.						
3.						

Will you be staying in: Tourist Hotels ☐ Relatives' Homes ☐ Local Accommodation ☐	Are you travelling with: Family Alone Partner Group
Is your holiday: An Organised Package Tour ☐ Organised by yourself ☐ A Backpacking Holiday ☐	Is your holiday for: Pleasure ☐ Business ☐

Will you be:
Going on Safari ☐
Travelling in areas of poor communication ☐
Participating in adventure sports ☐

PLEASE SUPPLY DETAILS OF YOUR PERSONAL MEDICAL HISTORY

	Yes	No	If yes please give details:
Will you be in areas where medical help is non-existent? (even for a short period)			
Are you suffering from any minor ailments?			
Do you have any long-term medical conditions?			
Do you have a history of epilepsy?			
Have you ever experienced anxiety, depression or other psychological problems which have required treatment?			
Have you had your spleen removed?			

	Yes	No	If yes please give details:
Have you ever had a bad reaction to a vaccine?			
Do you have any other allergies, e.g. eggs?			
Are you taking any medication including the oral contraceptive pill, or have you been on antibiotics within the last 10 days?			
Are you HIV positive?			
Have you recently received treatment with radiotherapy, chemotherapy or steroids?			
Are any children who are travelling up to date with their childhood vaccinations?			
Have you previously had any vaccinations?			
Women Only			
Are you pregnant?			
Are you breast feeding?			
Are you planning a pregnancy while you are away?			

VACCINATION HISTORY			
Have you had any of the following vaccinations:	**Yes**	**No**	**If yes when did you have the vaccination?**
Typhoid			
Tetanus			
Polio			
Hepatitis A			
Hepatitis B			
Diptheria			
Japanese Encephalitis			
Tick-borne Encephalitis			
Meningitis			
Rabies			
Yellow Fever			
BCG			