



PRIVATE AND CONFIDENTIAL

Surname:		First name:		Gender:	
Address:					
Email:			Contact number:		
Employer (if attending for overseas posting):			DOB:		

ITINERARY & PURPOSE OF VISIT

Country/countries to be visited	Departure Date	Length of trip in days	Reason for trip: Holiday/Business/Study/ Volunteering/Sport

LOCATION AND ACCOMMODATION – Please tick all that apply.

Location	Tick	Type of trip	Tick	Type of accommodation	Tick
Coastal areas		Backpacking		All-inclusive package	
Inland/rural areas		Organised trip		4 /5 * Hotels	
Urban areas		Independent travel		Other hotels / guest houses	
Safari		Pilgrimage		Hostels	
Jungle		Visiting friends/relatives		Safari Lodge	
High altitude		Healthcare elective		Camping/sleeping rough	
Remote locations		Community volunteering		Friends / Relatives	
Areas of civil unrest		School trip		Cruise ship/boat	
Ocean/river		Sport related			

VACCINATION HISTORY. Please provide dates of vaccinations you have had in the past: (B = Booster)

Vaccine	Date/s	Vaccine	Date/s	Vaccine	Date/s
Tetanus		Diphtheria		Polio	
Rabies	1 st 2 nd 3 rd B	Hepatitis A	1 st 2 nd B	Hepatitis B	1 st 2 nd 3 rd
MMR		Yellow Fever		Typhoid	
Cholera		BCG		Meningitis ACWY	
Japanese B Encephalitis	1 st 2 nd	3 rd	Tick Borne Encephalitis	1 st 2 nd	3 rd

MEDICAL HISTORY. Please answer the following questions:

Question	Answer	Details
Do you have any medical conditions?	Yes/No	Please list:
Are you taking any medication?	Yes/No	Please list:
Have you received any live vaccinations in the past 3 months?	Yes/No	
Have you received radiotherapy, chemotherapy or steroid therapy in the past year?	Yes/No	
Are you taking any medication that affects your immune system? Please give details.	Yes/No	
Do you have a condition that affects your immune system e.g. HIV?	Yes/No	
Do you have any allergies to drugs, substances (e.g. latex) or foods, including eggs or chicken protein?	Yes/No	
Have you had a serious reaction to a vaccination in the past?	Yes/No	
Does having an injection make you feel faint?	Yes/No	
Females only: Are you pregnant, breastfeeding, or planning to become pregnant in the near future?	Yes/No	
Are you fit and well today? (e.g. no acute infection or high temperature)	Yes/No	

Date: ____ / ____ / ____

Signature: _____

Subsequent visits

Date	Has there been any change in your health since previous declaration? If yes, give details.	Signature

Date	Notes	Signature

Travel health risk assessment: To be completed by Travel Consultant

Date	Notes	Signature

Source of advice for all Robens travel risk assessments is 'Travel Health Pro' (NaTHNaC)

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To be completed by Travel Consultant

	Course	Date	Date	Date	Date
Hepatitis B Day 0,7, 21 & 1 year Day 0, 1m,2m & 1 year Day 0, 1m & 6m					
Twinrix Day 0,7,21 & 1 year Day0,1m & 6m					
RABIES Day 0,7 & 28 Day 0,7 & 21 Day 0, 3, 7 and 12 months					
Japanese B Encephalitis Day 0 & 28 Day 0,7 (aged 18-64 years) Day 0, 7 (aged 65+) PSD ONLY					
Tick-borne Encephalitis Day 0, 1-3m, 5-12 m after 2 nd Day 0, 14 days, 5-12 m after 2 nd					

TRAVEL ADVICE AND LEAFLETS GIVEN TO PATIENT

Vaccine PILs offered/side effects of vaccines		Rabies risk/action		Malaria risk/advice	
Robens travel booklet		Altitude		Food and water precautions	
Post-vaccination advice		Blood borne infections (Hep B/HIV)		DVT prevention	
Insect/mosquito bite prevention - PHE leaflet given		Sun/heat protection		Country specific information: -Printed -To be emailed	
Sexual health		Traveller's diarrhoea		Insurance advice	
Zika virus		NaTHNac YF leaflet		Personal safety/security	

Other advice given:

Date	Time	Vaccine	Batch no	Exp date	Route	Site	Signature

Client's name: _____ DOB: ____/____/____

Consent: I have received information on the risks and benefits of the vaccines recommended and consent to the vaccines being administered.

Please note: You are advised to inform your GP of the vaccinations you have received at the Robens.

Signature of Traveller: _____ Date: ____/____/____