

PLEASE COMPLETE AND BRING TO YOUR TRAVEL APPOINTMENT

PERSONAL DETAILS

| | | | |
|----------------|--|---------------|-------------|
| Family Name | | First Name(s) | |
| Date of Birth | | Gender | Male/Female |
| Contact Number | | | |
| Contact e-mail | | | |

DATES OF TRAVEL

| | |
|----------------|--|
| Departure Date | |
| Return Date | |

ITINERY & PURPOSE OF VISIT

| Country Visited | Length of stay | How far from medical help at destination? |
|-----------------|----------------|---|
| | | |
| | | |
| | | |

PLEASE DESCRIBE YOUR TRIP

| | | | | | | |
|------------------------------------|----------|--|----------------|--|-------------|--|
| Type of trip | Business | | Pleasure | | Other | |
| Holiday type | Package | | Self organised | | Backpacking | |
| | Camping | | Cruise ship | | Trekking | |
| Accommodation | Hotel | | Residential | | Other | |
| Travelling | Alone | | With a friend | | In a group | |
| Staying in an area which is | Urban | | Rural | | Altitude | |
| Planned activities | Safari | | Adventure | | Other | |

PERSONAL MEDICAL HISTORY

Do you have any recent or past medical history of note? (including diabetes, heart or lung conditions)

List any current or repeat medications

Please list any allergies?

Have you ever had a serious reaction to a vaccine?

Do you have any history or mental illness including depression or anxiety?

Have you taken out travel insurance and if you have a medical condition, informed the insurance company about it?

Women only: Are you pregnant or planning pregnancy or breast feeding?

Please provide any further information which may be relevant

PLEASE LIST THE DATES OF ANY VACCINATIONS YOU HAVE HAD

| | | | | | |
|-----------------|--|--------------|--|-------------|--|
| Tetanus | | Polio | | Diphtheria | |
| Typhoid | | Hepatitis A | | Hepatitis B | |
| Meningitis | | Yellow Fever | | Influenza | |
| Rabies | | Jap B Enceph | | Tick Borne | |
| Other | | | | | |
| Malaria Tablets | | | | | |

DECLARATION

The information I have provided above is accurate to the best of my knowledge and:

- I have no reason to think that I might be pregnant.
- I have received information on the risks and benefits of the vaccines recommended and have had the opportunity to ask questions. I consent to the vaccines being given.
- I understand that charges may apply and I have been shown, and agree to pay, the current rates.

SIGNATURE

Date