

**OAKS PARTNERSHIP
TRAVEL HEALTH ASSESSMENT FORM**

PERSONAL DETAILS				
Name:		Date of birth: Male [] Female []		
Home phone number:		Mobile phone number:		
DATES OF TRIP				
Date of departure:				
Return date or overall length of trip:				
ITINERARY AND PURPOSE OF VISIT				
Country to be visited	Length of stay	Away from medical help at destination, if so how remote?		
1.				
2.				
3.				
PLEASE TICK AS APPROPRIATE BELOW TO BEST DESCRIBE YOUR TRIP				
1. Type of trip	Business		Pleasure	Other
2. Holiday Type	Package		Self organized	Backpacking
	Camping		Cruise ship	Trekking
3. Accommodation	Hotel		Relatives/ family home	Other
4. Traveling	Alone		With family/ Friend	In a group
5. Staying in area which is	Urban		Rural	Altitude
6. Planned activities	Safari		High risk i.e.: Paragliding/ white water rafting	Other
PERSONAL MEDICAL HISTORY				
Do you have any recent or past medical history of note? (including diabetes, heart or lung conditions or epilepsy)				
List any current or repeat medications				
Do you have any allergies i.e.: to eggs, nuts?				
Have you ever had a serious reaction to a vaccine given to you before?				
Does having an injection make you feel faint?				
Do you have any history of mental illness including depression or anxiety?				
Have you undergone radiotherapy, chemotherapy or steroid treatment within the last 6 months?				

Women only: Is there any risk you may be pregnant, or are you breast feeding?

Have you taken out travel insurance? Have you informed the company of any medical conditions you have?

Please state any further information which may be relevant.

VACCINATION HISTORY

Have you ever had any of the following vaccinations/malaria tablets and if so, when?

TETANUS		POLIO		DI PHTHERI A	
TYPHOID		HEPATI TIS A		HEPATI TIS B	
MENINGITIS		YELLOW FEVER		INFLUENZA	
RABI ES		JAPANESE B ENCEPHALI TIS		TICK BORNE ENCEPHALI TIS	
OTHER					
MALARIA TABLETS					

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.

Signed.....Date.....

SURGERY USE ONLY

VACCI NATIONS REQUI RED:

HEP A		TYPHOI D	
HEB B		DTPOL	
OTHERS (SPECI FY)			