THE WESTERN ROAD SURGERY BILLERICAY

Travel Risk Assessment

*** Travel advice will be provided via text or email. ***

Personal details		
Name	Date of Birth	
Telephone number	Email	
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX		
Departure date	Length of trip	
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX		
Country and location to be visited	Length of stay	City/Beach/Other (please state)

Type of trip	Holiday		Business		Volunteering (please provide details)	
Holiday Type	Package	Self organised	Cruise	Camping	Backpacking	Trekking
Accommodation	Hotel		Relatives/Family home		Other (please state)	
Travelling	Alone		With Family/Friends		In a group	
Area type	Urban		Rural		Altitude	
Planned activities	Safari		Adventure		Other (please state)	

Relevant past medical history	eg -Diabetes,Heart or Lung conditions, Epilepsy, Immunosuppression.
Allergies	
Current Medication	eg – blood thinning medications
Recent Radiotherapy, Chemotherapy or Steroid treatment.	
Are you pregnant, planning pregnancy or breastfeeding?	
Any other information that may be relevant	

VACCINATION HISTORY					
Have you ever had any of the following vaccinations/antimalarial tablets? Give dates if possible.					
Tetanus		Rabies		Diptheria	
Typhoid		Jap B Enceph		Polio	
Hepatitis A		Meningitis		Yellow Fever	
Hepatitis B		MMR		Tick Borne Enceph	
Antimalarial Tablets		Malarone		Doxycycline	Mefloquine/Larium

I confirm that to the best of my knowledge all information given is true and accurate at time of submitting this form.

NAME.....

SIGNATURE.....

DATE.....