**ATHOLL MEDICAL CENTRE, PITLOCHRY** 

**TEL NO: 01796 472558**

Please fill in one form for **EACH** traveller – **FOR FURTHER ADVICE AND INFORMATION, PLEASE VISIT THE TRAVELWEBSITE – WWW.FITFORTRAVEL.NHS.UK**

### NAME……………………………………….. ADDRESS……………………………………

### DATE OF BIRTH…………………………………. TELEPHONE………………………………………

WHEN DO YOU LEAVE?................................ LENGTH OF TRIP…………………………………

**COUNTRY YOU ARE VISITING** ……………………………………………………………………

**TYPE OF TRIP** **e.g. package holiday, backpacking** ……………………………………………………

**ARE YOU STOPPING ANYWHERE ON THE JOURNEY?** e.g. to change flights **❒ Yes ❒ No**

**IF YES, WHERE AND FOR HOW LONG?** …………………………………………………………….

#### ARE YOU STAYING ❒ Hotel ❒ Private Home ❒ Camping ❒ Sleeping Rough

#### HAVE YOU BEEN IMMUNISED PREVIOUSLY AGAINST

Tetanus ❒ Yes – What Year ……. ❒ No Yellow Fever ❒ Yes – What Year …………❒ No

Polio ❒ Yes – What Year…….. ❒ No Rabies ❒ Yes – What Year …………❒ No

Typhoid ❒ Yes – What Year…….. ❒ No Hepatitis A ❒ Yes – What Year …………❒No

Meningitis ❒ Yes – What Year…….. ❒ No Hepatitis B ❒ Yes – What Year …………❒ No

Cholera ❒ Yes – What Year…….. ❒ No Others e.g. Rubella ❒ Yes – What Year …….…. .❒ No

#### DO YOU HAVE A MEDICAL PROBLEM REQUIRING REGULAR SUPERVISION ❒ Yes ❒ No

**IF YES, WHAT?** ……………………………………………………………………………………………………

# ARE YOU TAKING STEROIDS? ❒ Yes ❒ No

# DO YOU TAKE ANY REGULAR MEDICATION? ❒ Yes ❒ No

# ARE YOU PREGNANT? ❒ Yes ❒ No

# HAVE YOU REACTED BADLY TO ANY PREVIOUS VACCINE? ❒ Yes ❒ No

# IF YES, WHICH VACCINE? …………………………………………………………………………………………………..

# ARE YOU ALLERGIC TO ANY MEDICINES? ❒ Yes ❒ No IF YES, WHICH? ……………………………

# ANY ADDITIONAL INFORMATION ……………………………………………………………………………………….

# PREGNANCY WARNING

You are advised to take adequate precautions to avoid pregnancy whilst you are taking anti-malarial tablets.

PATIENTS SIGNATURE …………………………………………….. DATE ……………………………….

(Parent if under 16)

**On completion of this travel form please return it to ATHOLL MEDICAL CENTRE and make a telephone appointment with Marie Stephen, Practice Nurse on a Thursday morning on the above number to discuss your requirements.**

**PLEASE NOTE WE ONLY PROVIDE NHS VACCINES (OTHER VACCINES ARE AVAILABLE IN PRIVATE CLINICS).**

**ALL ANTI-MALARIAL MEDICATION IS PROVIDED ON A PRIVATE BASIS.**

**IMMUNISATION FOR FOREIGN TRAVEL**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Vaccines** | **Required** | **Previously Immunised** | **Script Required** | **Script Done** | **Dates** | **Given** | **Comp** | **Claim** |
| Tetanus/Dip/Polio |  |  |  |  |  |  |  |  |
| Typhoid |  |  |  |  |  |  |  |  |
| Hep A |  |  |  |  |  |  |  |  |
| Hepatyrix |  |  |  |  |  |  |  |  |
| Hep B |  |  |  |  |  |  |  |  |
| Meningococcal |  |  |  |  |  |  |  |  |
| Japanese Encephalitis |  |  |  |  |  |  |  |  |
| Rabies |  |  |  |  |  |  |  |  |
| BCG |  |  |  |  |  |  |  |  |
| Yellow Fever |  |  |  |  |  |  |  |  |
| Other |  |  |  |  |  |  |  |  |

**MALARIA CHEMOPROPHYLAXIS**

|  |  |
| --- | --- |
| Chloroquine |  |
| Proguanil |  |
| Mefloquine |  |
| Doxycycline |  |
| Malarone |  |

# ADVICE

|  |  |
| --- | --- |
| Malaria |  |
| Sun Protection |  |
| Diarrhoea |  |
| Altitude Sickness |  |
| Safe Sex |  |
| Written Information Given |  |

# CHECKLIST

|  |  |  |
| --- | --- | --- |
| Current Febrile Illness? | Yes | No |
| Chronic Illness? | Yes | No |
| Steroid Therapy? | Yes | No |
| Cancer Therapy? | Yes | No |
| Pregnancy? | Yes | No |
| Vaccination in last 3 weeks? | Yes | No |
| Known Allergies? | Yes | No |
| Immunosuppressed in Household? | Yes | No |
| Travel Booklet Given? | Yes | No |

# CHEMIST

|  |  |
| --- | --- |
| Davidsons 1 |  |
| Davidsons 2 |  |