Travel Risk Assessment Form

Name: Date of birth:

Address: Telephone:

Email:

Travel details

Departure date: Return date:	Total length of trip:	
Country/Destinations	Region	Length of stay
1.		
2.		
3.		
4.		
5.		
6.		

Purpose of trip

Adventure/Gap year

Aid work/ Emergency response:

Business/work trip:

Charity/Volunteer:

Cruise:

Diving:

Health worker

Holiday:

Long term/Expatriate:

Medical treatment:

Pilgrimage:

Visiting friends and family:

Other:

Medical History

Please tick either the 'Yes' or 'No' answer box. If you answer yes to any of the questions, please give dates and full details overleaf.

		Yes	No
1)	Do you have, or have you had any serious illness, disability or mobility problem?	❒	❒
2)	Are you receiving regular treatment or follow up with your GP/Hospital specialist?	❒	❒
3)	Have you had any hospital admissions?	❒	❒
4)	Have you ever had any surgery?	❒	❒
5)	Do you have any allergies?	❒	❒
6)	Have you had any travel related illness/injury which required assessment/treatment in hospital?	❒	❒
7)	Do you have a condition which may suppress your immune system?	❒	❒
8)	Do you think you have a condition which may be affected by travel?	❒	❒
9)	Do you have any specific health concerns regarding your proposed trip?	❒	❒
10)	Have you ever experienced any mental health issues, even mild anxiety or depression?	❒	❒

Further Details

Please provide any other important information regarding your health, including problems experienced with previous travel:

Please continue on a separate sheet if necessary.

Are you taking any form of medication?

Yes ❒ No ❒

If yes please give details, including prescribed/self-treatment/over-the-counter remedies and contraception

Name of Medication	Dose and Frequency	Condition

Women only

Are you pregnant, breastfeeding or planning pregnancy whilst travelling?

Yes ❒ No ❒

Babies and children only

Current weight: Date:

Do you have travel health insurance? Yes ❒ No ❒

Next section is for health professional use only:

Risk Management Checklist	Discussed (✓)	Comments
1. Medical Prep		
2. Journey		
3. Safety		
4. Environmental		
5. Food and Water		
6. Vector-borne Risks		
7. Sexual health		
8. Blood-borne virus		
9. Skin/sun		
10. Psychological Health		

Signature…… Date……..

Vaccine Record

Vaccines	Date	Brand, Batch & Expiry Date	Dose, method & site	Given by
BCG and Mantoux Test Mantoux result:				

Cholera **Primary course:** **Boosters**				
Diphtheria/Tetanus/Polio				
Hepatitis A: **Primary course:** **Boosters**				
Hepatitis A/B: **Primary course:** **Boosters**				
Hepatitis A/Typhoid **Primary course:** **Boosters**				
Hepatitis B: **Primary course:** **Boosters**				
Japanese Encephalitis: **Primary course:** **Boosters**				
Influenza				
Japanese Encephalitis **Primary course:** **Boosters**				
Meningitis ACWY				

MMR				
Tick-borne encephalitis **Primary course:** **Boosters**				
Typhoid				
Yellow fever				
Any other vaccines				

Malaria

Antimalarials	**Date prescribed**	**Dose & amount dispensed**	**Batch number & expiry date**	**Given by**
Atovaquone & proguanil				
Chloroquine				
Doxycycline				
Mefloquine				
Proguanil				
Emergency standby				

Importance of bite avoidance and urgent medical attention for symptoms discussed?

YES ❒ NO ❒

Any other advice or comments: