TRAVEL VACCINATION FORM

HAMPTON MEDICAL CENTRE

ONE FORM PER PATIENT

Please ensure all information is filled in correctly.

Please complete this form if you are travelling within the next 3 months. If you are travelling within the next 2 weeks, please contact a private travel clinic, as we may not have enough time to arrange the appropriate travel vaccinations before your departure.

Patient Name:_____

Date of Birth:_____/_____/_____

Address:_____

Sex: Male Female Prefer not to say

Nationality:_____

Contact number:_____

Place of Employment:_____

About your trip:

Date of travel:_____/_____/_____

Length of stay: _____ Days / Weeks / Months

Country/ies travelling to: _____

_____

Accommodation type

Hotel ☐ (Star)

Self Catering ☐

Back Packing ☐

Safari ☐

Are you partaking in high-risk activities?

Previous Vaccination History:

If you are aware of what previous vaccines you have received, please complete the following table, otherwise, please leave blank for our nursing team to complete.

Vaccine	Year given
Tetanus	
Diphtheria	
Polio	
Typhoid	
Hepatitis A	
Hepatitis B	
Meningitis	
Yellow Fever	
Other:	

For HMC Admin Staff:

Travel Triage Call Booked

Date:

With:

Recommended Vaccinations:

Tetanus ☐ Diphtheria ☐ Polio ☐
Jap B Ench
Hepatitis A ☐ Hepatitis B ☐
Typhoid
Meningitis ACWY
Yellow Fever
Cholera
Rabies
Private malaria script

Appointment Date:

Appointment Time:

Nurse:

Payment Method: