WEST DERBY MEDICAL CENTRE
3 WINTERBURN CRESCENT
WEST DERBY
LIVERPOOL
L12 8TQ

Phone: (0151) 228 3768
Phone: (0151) 259 2900
Fax: (0151) 259 7008
westderby.mc@nhs.net
www.westderbymc.nhs.uk

HOLIDAY VACCINATION

The surgery offers a **limited** Travel Vaccination service.

Appointments need to be made at least 4-6 weeks prior to travel.

You must COMPLETE THE QUESTIONNAIRE attached to this form and BRING IT WITH YOU to your appointment along with A LIST OF VACCINES YOU REQUIRE.

FAILURE TO DO SO WILL RESULT IN YOUR APPOINTMENT BEING POSTPONED.

We would ask that you contact one of the agencies listed below to find out which vaccines you require for your destination before attending your appointment and bring this information with you:
www.fitfortravel/nhs.uk
www.nathnac.org

You can attend the below clinic for advice and vaccines at a charge:
Well Travel Clinics
Liverpool School of Tropical Medicine
Pembroke Place
Liverpool
L3 5QA
Telephone: 0151 705 3223
Fax: 0151 705 3365

Drop in pre-travel clinic at above:
Mon – Fri 8:45 – Noon (Doors open at 8:30)
Appointments also available afternoons, evenings and Saturday mornings. When you book an appointment you will be asked for Credit/Debit card details. Failure to attend or if you cancel your appointment less than 24 hours before, you will be charged a £20 cancellation fee per person.

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TRAVELLING WITH CHILDREN

Some vaccines for children e.g. Hepatitis A requires a prescription which must be ordered at least 48 hours before you attend your appointment and brought to the surgery when you attend. Please store vaccine in the fridge until your appointment.

Vaccines free of charge at GP surgery

Hepatitis A
Diptheria & Tetanus & Polio
Typhoid

Vaccines available only at The School of Tropical Medicine

Yellow Fever
Japanese Encephalitis

Some anti-malarial tablets need a private prescription from the GP (via an appointment) or The School of Tropical Medicine:

Mefloquine
Malarone
Doxycycline

Personal details

Name:	Date of birth: Male [ ] Female [ ]
Easiest contact telephone number: E mail:	

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.		
Future travel plans		

Please tick as appropriate below to best describe your trip

1. Type of trip	Business		Pleasure		Other	
2. Holiday type	Package		Self-organised		Backpacking	
	Camping		Cruise ship		Trekking	
3. Accommodation	Hotel		Relatives/family home		Other	
4. Travelling	Alone		With family/friend		In a group	
5. Staying in area which is	Urban		Rural		Altitude	
6. Planned activities	Safari		Adventure		Other	

Personal medical history

Do you have any recent or past medical history of note? (including diabetes, heart or lung conditions)

List any current or repeat medications

Do you have any allergies for example to eggs, antibiotics, 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 or any close family members have epilepsy?

Do you have any history or mental illness including depression or anxiety?

Have you recently undergone radiotherapy, chemotherapy or steroid treatment?

Women only: Are you pregnant or planning pregnancy or breastfeeding?

Have you taken out travel insurance and if you have a medical condition, informed the insurance company about this?

Please write below 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		Diphtheria	
Typhoid		Hepatitis A		Hepatitis B	
Meningitis		Yellow Fever		Influenza	
Rabies		Jap B Enceph		Tick Borne	
Other					
Malaria Tablets					

For discussion when risk assessment is performed within your appointment:

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:………………………………………

FOR OFFICIAL USE
Patient Name:
Travel risk assessment performed Yes [ ] No [ ]

Travel vaccines recommended for this trip			
Disease protection	Yes	No	Further information
Hepatitis A			
Hepatitis B			
Typhoid			
Cholera			
Tetanus			
Diphtheria			
Polio			
Meningitis ACWY			
Yellow Fever			
Rabies			
Japanese B Encephalitis			
Other			

Travel advice and leaflets given as per travel protocol					
Food water and personal hygiene advice		Travellers' diarrhoea		Hepatitis B and HIV	
Insect bite prevention		Animal bites		Accidents	
Insurance		Air travel		Sun and heat protection	
Websites		Travel record supplied			
		Other			

Malaria prevention advice and malaria chemoprophylaxis			
Chloroquine and proguanil		Atovaquone + proguanil (Malarone)	
Chloroquine		Mefloquine	
Doxycycline		Malaria advice leaflet given	

Further information
e.g. weight of child

Signed by:………………………………………Position:……………………………………Date:………………….…….…