RISK ASSESSMENT FORM

Name:		**DOB:**	
Address:		**Contact No:**	
		Email:	
Itinerary:			

Medical History (mark as appropriate)

Are you well today?	Yes ☐ No ☐
Do you take medication (including prescribed/over the counter contraception)?	Yes ☐ No ☐
If YES, please list:	
Do you have any allergies (including latex/food/medication)?	Yes ☐ No ☐
If YES, please list:	
Women only: Are you pregnant, breast feeding or planning a pregnancy whilst travelling?	Yes ☐ No ☐
Any other medical conditions:	

Travel Vaccine	Date(s) received	Vaccine discussed and recommended. No contraindications	Administration schedule
Cholera			
Diptheria Tetanus Polio			
Hepatitis A			
Hepatitis B			
Hepatitis A/B			
Hepatitis A/ Typhoid			
Japanese Encephalitis			
Influenza			
Meningitis ACWY			
MMR			
Rabies			
TBE			
Typhoid			
Yellow Fever			

Antimalarials	Number required	Private Prescription
Doxycycline		
Mefloquine		
Malarone		
Weight		

Patient's signature		Date:
Nurse's signature		Date:
GP's signature		Date: