TRAVEL RISK ASSESSMENT FORM

If you have filled this in on line please save it to your computer and return a printed completed copy

NAME		DOB	
ADDRESS		BEST CONTACTABLE TEL NUMBER	
DATE OF TRAVEL		COUNTRIES TO BE VISITED	
ITINARY OF TRAVEL in detail PLEASE	1. 2. 3.	LENGTH OF STAY	

PLEASE TICK AS APPROPRIATE.

1.TYPE OF TRIP	BUSINESS		PLEASURE		OTHER	
2.HOLIDAY TYPE	PACKAGE		SELF ORGANISED		BACKPACKING	
	CAMPING		CRUISE SHIP		TREKKING	
3.ACCOMODATION	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	

Do you have any recent or past medical history? (Diabetes, heart, lung conditions or epilepsy).
Do you have a history of mental illness including depression or anxiety?
Do you have any allergies e.g. egg, antibiotics, nuts or latex?
Have you had a serious reaction to a previous vaccine?
WOMEN ONLY: Are you pregnant or planning a pregnancy or breast feeding?
Have you recently had radiotherapy, chemotherapy or steroid treatment?
Have you had any vaccinations or taken antimalarial tablets? If so what and when?