The Faythe Medical Centre
178 The Faythe, Wexford. Tel.: 053-9142355, Fax: 053-9141160, www.tfmc.ie

TRAVEL VACCINE CONSULTATION CHECKLIST

Personal Details:			
Name:			
Date of Birth:		Male ☐ Female ☐	
Contact Phone Number			
Dates of Trip:			
Date of Departure:		Date of Return:	
Itinerary and Purpose of Visit:			
Country to be visited	Length of stay	Away from medical help at destination, and if so, how remote?	

Future travel plans:

_____

_____

Please tick as appropriate below to best describe your trip:			
Type of trip:	☐ Business	☐ Pleasure	☐ Other
Holiday type:	☐ Package	☐ Self-organised	☐ Backpacking
	☐ Camping	☐ Cruise	☐ Trekking
Accommodation	☐ Hotel	☐ Relatives/family home	☐ Other
Travelling:	☐ Alone	☐ With family/friend	☐ In a group
Staying in area which is:	☐ Urban	☐ Rural	☐ Altitude
Planned activities:	☐ Safari	☐ Adventure	☐ Other

Travel medicine History:		
Do you have any recent or past medical history of note? (including diabetes, heart or lung conditions)	☐ Yes	☐ No

List any current or repeat medications:

_____

_____

Do you have any allergies, e.g. eggs, antibiotics, nuts?	☐ Yes	☐ No
Have you ever had a serious reaction to a vaccine given to you before?	☐ Yes	☐ No
Does having an injection make you feel faint?	☐ Yes	☐ No
Women only: Are you pregnant or planning pregnancy, or breastfeeding?	☐ Yes	☐ No

Please write below any further information which may be relevant:

_____

_____

↳P.T.O.

Travel medicine history:			
Have you ever had any of the following vaccines/malaria tablets and if so, when?			☐ Pertusis _____
☐ Tetanus _____	☐ Polio _____	☐ Diphtheria _____	☐ Typhoid _____
☐ Hepatitis A _____	☐ Hepatitis B _____	☐ Meningitis _____	☐ Yellow fever___
☐ Influenze _____	☐ Rabies _____	☐ Japense B Enceph ____	☐ Tick Borne Enceph
Other:			
Malaria Tablets:			
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:			Further information:
Hepatitis A	☐ Yes	☐ No	
Hepatitis B	☐ Yes	☐ No	
Typhoid	☐ Yes	☐ No	
Cholera	☐ Yes	☐ No	
Tetanus	☐ Yes	☐ No	
Diphtheria	☐ Yes	☐ No	
Polio	☐ Yes	☐ No	
Pertussis	☐ Yes	☐ No	
Meningitis ACWY	☐ Yes	☐ No	
Yellow Fever	☐ Yes	☐ No	
Rabies	☐ Yes	☐ No	
Japanese B Encephalitis	☐ Yes	☐ No	
Other			
Travel advice and leaflets given as per travel protocol			
☐ Food water and personal hygiene advice	☐ Travellers's 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	
☐ Chloroquine		☐ Mefloquine	
☐ Doxycycline		☐ Malaria advice leaflet given	
Further information			
E.g. weight of child			
Signed by: _____ Position: Date: _____ _____			