Risk Assessment Form

Personal Details

Name :

Date of Birth :

Male : ☐

Female : ☐

Address :

e-mail address :

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.			
3.			
4. Other Countries			

Please tick as appropriate below to best describe your trip

Type of trip :	☐ Business	☐ Pleasure	☐ Other
Holiday type:	☐ Package	☐ Self Organised	☐ Backpacking
	☐ Camping	☐ Cruise ship	☐ Trekking
Accommodation :	☐ Hotel	☐ Relatives /family home	☐ Other
Travelling :	☐ Alone	☐ With family /friend	☐ In a Group
Staying in areawhich is:	☐ Urban	☐ Rural	☐ Altitude

Personal medical history

- 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?
- Doeshaving an injection make you feel feint?
- Do you or any close family members have epilepsy?
- Do you have any history or mental illness including depression oranxiety?
- Have you recently undergone radiotherapy, chemotherapy or steroid treatment?
- Women only: Areyou pregnant or planning pregnancy or breast feeding?
- Have you taken out travel insurance and if you have a medicalcondition, informed the insurance company about his?
- Please write below any further information which may berelevant

Vaccination History

Have you ever had any of the following vaccinations / malaria tablets and if so when?

☐ Tetanus / mm/yy	☐ Polio / mm/yy	☐ Diphtheria / mm/yy
☐ Typhoid / mm/yy	☐ Hepatitis A / mm/yy	☐ Hepatitis B / mm/yy
☐ Meningitis / mm/yy	☐ Yellow Fever / mm/yy	☐ Influenza / mm/yy
☐ Rabies / mm/yy	☐ Jap B Enceph / mm/yy	☐ Tick Borne / mm/yy

Other :

Malaria tablets :