Island Travel Clinic
Travel Risk assessment form

Please complete this form prior to your travel clinic appointment (one form per person).

1. Personal Information			
Full Name:			
Date of Birth:		Sex:	☐ Male ☐ Female
Address:			
Daytime Tel Number:		Email Address:	

2. Existing GP Information (if not Island Medical Centre)			
GP Name:		Telephone Number:	
GP Address:			

3. Dates of Trip			
Departure Date:		Return Date:	

4. Itinerary and purpose of visit (including any stopovers)		
Country to be visited	Length of stay	Away from medical help at destination? If so, how remote?

5. Please select the description(s) that best describes your trip	
Type of Trip:	☐ Business/Work ☐ Pleasure ☐ Medical/Dental ☐ Other
Holiday Type:	☐ Package ☐ Self-Organised ☐ Backpacking ☐ Camping ☐ Cruise Ship ☐ Trekking ☐ Other
Accommodation:	☐ Hotel ☐Relatives/Family Home ☐ Other
Travelling:	☐ Alone ☐ With Family/Friend ☐ In A Group
Staying in area:	☐ Urban ☐ Rural ☐ Altitude
Planned Activities:	☐ Safari ☐ Adventure ☐ Other ☐

6. Personal Medical History
Do you have any recent or past medical history of note? (this includes diabetes, heart or lung conditions, thymus disorder): ☐ Yes ☐ No If Yes please provide details:
Do you currently take any medication?: ☐ Yes ☐ No If Yes please provide details of any current or repeat medication:

Do you have any allergies for example to eggs, antibiotics, nuts? ☐ Yes ☐ No

If Yes please provide details:

Have you ever had a serious reaction to a vaccine given to you before? ☐ Yes ☐ No

If Yes please provide details:

Does having an injection make you feel faint? ☐ Yes ☐ No

If Yes please provide details:

Do you or any close family member have epilepsy? ☐ Yes ☐ No

If Yes please provide details:

Do you have any history of mental illness including depression or anxiety? ☐ Yes ☐ No

If Yes please provide details:

Have you recently undergone radiotherapy, chemotherapy or steroid treatment? ☐ Yes ☐ No

If Yes please provide details:

Women only: Are you pregnant or planning pregnancy or breast feeding? ☐ Yes ☐ No

Have you taken out adequate travel insurance? If you have a pre-existing medical condition, have you informed the insurer about this?

☐ Yes ☐ No

Please give further information that may be relevant, including any future travel plans within six months of your return from this trip.

7: Applicant Declaration, Confidentiality Agreement and Personal Data Statement

I confirm that all the information I have given is correct. Where applicable I have no reason to think that I am pregnant.

Where vaccinations are given I hereby give my consent. In respect of children under 16, I give my consent as their parent/legal guardian.

The information collected on this form will be held in accordance with the Data Protection (Jersey) Law 2018 and will be used by Island Medical Centre Partnership (hereafter the 'Practice') for the purposes of travel healthcare and related services and administration.

I am aware that personal data relating to myself, whether obtained from myself or from any other source, will be retained by the Practice for the purposes of providing me with travel healthcare and related services both inside and outside of the Practice.

I acknowledge that this may require my personal data to be forwarded to other persons for the purpose of referrals and for other lawful purposes related to the Practice procedures.

I hereby consent to the holding and disclosure of my personal data by the Practice for the purposes and in the manner set out above and accept that the Practice will not be liable for any subsequent release of my details to any unauthorised third party through any method beyond its control.

I understand that the Practice has the right to accept or decline this application.

I agree to pay all travel vaccination treatment given by the Practice at the time of treatment.

Signed:	Print Name:	Date:

Island Travel Clinic
For ITC Use Only

To be completed during consultation with Travel Clinic nurse.

1. Patient Details			
Full Name:			
Date of Birth:		EMIS ID:	
Travel Risk Assessment Performed? ☐ Yes ☐ No		Assessment By Nurse:	

2. Travel Vaccines for This Trip

Disease Protection	Vaccinated Date	Vaccination Required	Vaccination Discussed	Vaccination Declined	Vaccine Given	Further Information
Hepatitis A		☐	☐	☐	☐	
Hepatitis B		☐	☐	☐	☐	
Typhoid		☐	☐	☐	☐	
Cholera		☐	☐	☐	☐	
Tetanus		☐	☐	☐	☐	
Diphtheria		☐	☐	☐	☐	
Polio		☐	☐	☐	☐	
Meningitis ACWY		☐	☐	☐	☐	
Yellow Fever		☐	☐	☐	☐	
Rabies		☐	☐	☐	☐	
Japanese B Encephalitis		☐	☐	☐	☐	
MMR		☐	☐	☐	☐	
COVID-19		☐	☐	☐	☐	
Others						

Travel Advice Leaflet Given as Per Travel Protocol: ☐ Yes ☐ No

3. Malaria Prevention Advice and Malaria Chemoprophylaxis

☐ Chloroquine and proguanil ☐ Atovaquone + proguanil (Malarone)

☐ Chloroquine ☐ Mefloquine ☐ Doxycycline ☐ Malaria advice leaflet given

Further Information: eg weight of Child:

Given by GP:	Date:

All pages of forms to be scanned to patient record in EMIS	Scanned Date:	