

# Pre-Immunisation Form

Name:  
Address:

DOB: No:  
If the address or email given is incorrect please correct below:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Email:

## TRAVEL ITINERARY

Date of departure: \_\_\_\_\_  
Duration of stay: \_\_\_\_\_

Destination: \_\_\_\_\_  
Accommodation: \_\_\_\_\_

## PREVIOUS/CURRENT MEDICAL HISTORY

Are you feeling well today?  Yes  No  
Are you taking regular medication?  Yes  No  
Are you taking regular antimalarials?  Yes  No

Have you EVER suffered from any of the following:

Heart condition  Yes  No  
Blood condition  Yes  No  
Lung condition  Yes  No  
Kidney condition  Yes  No  
Skin condition  Yes  No  
Any other condition  Yes  No

Have you or anyone in your immediate family ever suffered from any of the following:

Serious psychological problems  Self  Family  No  
Sleep disturbance  Self  No  
Anxiety  Self  No  
Depression  Self  Family  No  
Epilepsy  Self  Family  No

Are you taking any medication which may affect your immune system  Yes  No  
Do you have any allergies/sensitivities?  Yes  No

Please Indicate: \_\_\_\_\_

\_\_\_\_\_

Current health problems: \_\_\_\_\_

\_\_\_\_\_

Current Medication: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I certify that the above answers are true to my knowledge:

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

Please hand this form back to reception when you have completed as much as you can.

## For Women Only

Are you pregnant?  Yes  No  
Are you planning a pregnancy?  Yes  No  
Date of last menstrual period: \_\_\_\_\_

## PREVIOUS VACCINATION HISTORY

Previous reaction to any vaccines  Yes  No  
Feels faint with injections  Yes  No

Vaccine		Date of initial course	Date last given
Polio	<input type="checkbox"/>		
Tetanus/Diphtheria	<input type="checkbox"/>		
Typhoid	<input type="checkbox"/>		
Hepatitis A	<input type="checkbox"/>		
Hepatitis B	<input type="checkbox"/>		
Cholera	<input type="checkbox"/>		
Rabies	<input type="checkbox"/>		
Yellow Fever	<input type="checkbox"/>		
Meningitis ACWY	<input type="checkbox"/>		
Japanese Encephalitis	<input type="checkbox"/>		
Tick-born Encephalitis	<input type="checkbox"/>		
Flu	<input type="checkbox"/>		
BCG/Heaf/Mantoux	<input type="checkbox"/>		

## VACCINE HISTORY FOR CHILDREN

Please tick if the child has had any of the following immunisations:

DPT  1st  2nd  3rd  
Polio  1st  2nd  3rd  
Hib  1st  2nd  3rd  
Meningitis C  1st  
BCG  1st  
MMR  Yes  No

Blood group if known: \_\_\_\_\_

## CONSENT:

To be completed during the consultation

I authorise InterHealth to administer the vaccines as explained to me

Signed: \_\_\_\_\_

Date: \_\_\_\_\_