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|  | **Occupational Health Services** |

Travel Risk Assessment Questionnaire

Please complete this questionnaire and bring it completed to your travel health consultation:

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| Title: Prof/ Dr/ Mr/ Mrs/ Miss/ Ms/ Other | |
| Full Name: | |
| Address: | |
| Post Code: | Date of Birth: |
| Job Title: | |
| Department: | |
| Contact Tel No: | |
| Date commenced post: | |

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| 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. | | | |

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| Please circle the descriptions that best describe your trip: | | | | | | |
| 1. **Reason for travel** | | University Business | Funded Research Project | | Elective Placement | Other:(please specify) |
| Account / Project Code  If project code, please add Task Code | | Account code | Account or Project & Task Code: | | Payment by credit / debit card at appt. | Payment may be required at appt. |
| 1. **Travel type:** | Package | Self Organised | Backpacking | Camping | Cruise ship | Trekking |
| 1. **Accommodation:** | | Hotel | | Relatives/family home | | Other |
| 1. **Travelling:** | | Alone | | With family/friend | | In a group |
| 1. **Staying in area which is:** | | Urban | | Rural | | Altitude |
| 1. **Planned activities:** | | Safari | | Adventure | | Other |

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| **Personal medical history:**  Do you have any recent or past medical history of note? This includes diabetes, heart or lung conditions, thymus disorder.(if yes please specify): | | |
| List any current or repeat medications: | | |
| **(Please ✓ where applicable)** | **Yes** | **No** |
| Do you have any allergies for example to eggs, antibiotics, nuts?  (if yes please specify) |  |  |
| Have you ever had a serious reaction to a vaccine given to you before?  (if yes please specify) |  |  |
| Does having an injection make you feel faint? |  |  |
| Do you or any close family members have epilepsy?  (if yes please specify) |  |  |
| Do you have any history or mental illness including depression or anxiety?  (if yes please specify) |  |  |
| Have you recently undergone radiotherapy, chemotherapy or steroid treatment?  (if yes please specify) |  |  |
| **Women only**: Are you pregnant or planning pregnancy or breast feeding?  (if yes please specify) |  |  |
| Have you taken out travel insurance? |  |  |
| If you have a medical condition, have you informed the insurance company about this? |  |  |

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| **Vaccination History:**  Have you ever had any of the following vaccinations/malaria tablets, and if so when?  (Please tick if applicable) | | | |
| Tetanus:  Date: | Polio:  Date: | Diphtheria:  Date: | Influenza:  Date: |
| Typhoid:  Date: | Hepatitis A:  Date: | Hepatitis B:  Date: | Meningitis:  Date |
| Jap B Encephalitis:  Date: | Yellow Fever:  Date: | Rabies:  Date: | Tick Borne Encephalitis:  Date: |
| MMR  Date: | Pertussis (Whooping Cough)  Date: | Varicella (Chicken Pox)  Date: |  |
| Other:  Date: | | | |
| Malaria Tablets: | | | |

The information supplied by you on this questionnaire will be used to produce a certificate. This will be forwarded to your Line Manager / Supervisor / School Administrator as evidence of your fitness to travel.

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| Name: | Signature: | Date: |