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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: |
| MMRDate: | 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: |