I M P O R T A N T - It is preferable that your Travel Consultation appointment is made one month prior to your departure. Please return this record this form promptly. You will be advised of an appointment time and date.

P L E A S E N O T E - There will be a charge for each person, even if your travel has been discussed previously with your own GP.

TRAVELLER'S MEDICAL RECORD

NIRVANA

DATE ________________________

FIRST NAME ________________________________SURNAME ________________________________

ADDRESS

____

____

POST CODE ______________

DATE OF BIRTH ___________________________ Ethnicity ________________________________

TELEPHONE ______________________________ MOBILE PHONE _____________________________

I (FULL NAME)____ hereby consent to the administration to myself of the vaccines as listed below.

YOUR HEALTH

1. Have you travelled to less developed countries before? *Yes / No*

Did you have any health problems while away? *Yes / No*

If yes, please specify...

2. Do you have or have you ever had any medical problems? eg, asthma, blood clots, cancers, chronic bronchitis, anxiety attacks or depression, diabetes, epilepsy, heart disease, HIV/AIDs, mental illness, stomach ulcer, splenectomy, schizophrenia, weakness of immune system, *Yes / No*

If yes, please specify...

3. Have you been in hospital in the last year? *Yes / No*

4. Have you had a blood transfusion? *Yes / No*

5. Have you ever had hepatitis? *Yes / No*

6. Are you taking any medication now? eg: contraceptive pill, antibiotics or do you occasionally take medication? eg: migraine tablets, ventolin, vitamins *Yes / No*

If yes, please specify...

7. Do you have any known allergies? e.g. : sulphur drugs, eggs, nuts, penicillin, bee stings, iodine, neomycin, latex, band aids? *Yes / No*

If yes, please specify...

8. Women only: Are you pregnant or is it a possibility on your return? *Yes / No*

9. Please list any past vaccinations and date/year of administration: BCG Diphtheria/Tetanus Typhoid Hep A Hep B Meningitis Influenza MMR Rabies Polio Yellow Fever

Other...

10. Do you have any particular health concerns regarding this trip? *Yes /No*

Please outline ....

NIRVANA

YOUR TRIP

11. Please list in order the countries you intend visiting, and how long you plan to spend in each:

....days

....days

....days

....days

....days

....days

....days

12. What is the main purpose of your trip? (Please circle) Holiday Visiting family/friends Business Trip

Other ____

13. Type of Accommodation? (Please tick) Camping Budget Air Conditioned Hotel Private Home

Other ____

14. Planned activities? (Please tick) Trekking / Altitude Scuba Diving Cycling Rafting / Boating

Other ____

15. Date leaving New Zealand _________________________

Date returning to New Zealand _________________________

NIRVANA

PRE-TRAVEL WORKSHEET (to be discussed with Medical Staff)

Vaccine : Number of Doses Required . Please tick the vaccinations you wish to have.

1. Hepatitis A One injection, booster at 12 months will provide immunity up to 10 years

2. Hepatitis A & B Course of three injections. 0, 1 and 6 months.

3. Hepatitis B Course of three injections one month apart. Life long immunity.

4. Japanese Encephalitis Two injections. 1, 28 days after first injection

5. Meningococcal ACYW135 (Menectra) One injection. Booster at 3 years.

6. Polio One injection if had childhood immunisation. Booster every 10 years.

7. Rabies Three injections. 0, 7, 28 days. Booster at one year.

8. Tetanus - Give one injection if more than 10 years since previous booster dose.

9. Typhoid One injection. OR 3 capsules taken on Day 1, day 3 and day 5 -Three yearly booster.

10. Hepatitis A / Typhoid Booster six months. Revaccinate against Typhoid every three years.

11. Cholera - Two sachets taken 1 week apart - Booster if needed at 2 years.

12. Yellow Fever - One injection - life long immunity

13. Other -e.g. Influenza, pneumococcal, tick borne encephalitis ....
....

RECOMMENDED MALARIA PROPHYLAXIS / ORAL MEDS

....
.. ..
....

I have been informed of the following:

- The vaccines being given today
- The care after vaccination
- The risks of vaccination
- The possible side effects
- The procedure to follow in the case of an adverse event

I am satisfied that I have received enough information today explaining both the benefits and risks of the vaccines to be administered. Any questions I had have been answered to my satisfaction. I have been informed as to the immunisation.

NIRVANA

Sheet Prepared by .... Nurse

Sheet Prepared by .... Doctor

Date ....

I agree to pay the full cost of the vaccines before administration.

PATIENT'S SIGNATURE ____

Date ________________________

NIRVANA