OFFICE USE ONLY	
Cleared by Travel Nurse	
Cleared by Manager	
Certificate Issued	

STUDENT ELECTIVE TRAVEL RISK ASSESSMENT
UEA Occupational Health Department

SECTIONS 1-3 TO BE COMPLETED BY STUDENT (in advance of appointment)

(1) PERSONAL DETAILS

Name: **DOB:**		**E-mail:** **Contact Number(s):**
Address:	**Male / Female** *(delete as applicable)*	**GP Name & Address:**

(2) ELECTIVE TRAVEL PLANS

Travelling to:	Date:	Describe location (rural/city/jungle…)
1.		
2.		
3.		

What do you plan to do on your elective/placement?

(3) ADDITIONAL TRAVEL PLANS

Do you plan on travelling anywhere either before or after your elective?

☐ Yes
☐ No

If yes - where? (please state all countries)

SECTIONS 4-9 TO BE COMPLETED BY TRAVEL HEALTH NURSE

(4) MEDICAL HISTORY

Current:

Previous:

Current Medication:

Allergies:

Any Allergic Reaction to Egg or Gelatine:
☐ Yes
☐ No

Any problem with vaccines?
☐ Yes
☐ No

FEMALE TRAVELLERS ONLY

Is there any risk of pregnancy?
☐ Yes
☐ No

Is patient planning a pregnancy?
☐ Yes
☐ No

LMP Date .....

(5) MALARIA PROPHYLAXIS

☐ Bite Avoidance
☐ Repellents
☐ Clothing
☐ Nets
☐ Prophylaxis
☐ S/S Malaria

Previous Malaria Prophylaxis?
☐ Yes
☐ No

Which .....

Any Problems?
☐ Yes
☐ No

Script Issued Date:

.....

Issued by:

.....

Signature:

.....

Does patient have a history of:
☐ Epilepsy
☐ Psoriasis
☐ Kidney/Liver Problems
☐ Asthma
☐ Diabetes
☐ Immunosuppression
☐ Steroid Therapy
☐ Anxiety/Depression

(6) PSD AUTHORISATION STATEMENT

Following completion of the Travel Risk Assessment, I hereby authorise the use of the recommended vaccines below as a Patient Specific Direction (PSD).

Dr Name: ..... **Dr Signature: .....** **Date: .....**

HIV Incidence in elective countries: **Script Issued Date:** ..... **Issued by:** ..... **Signature:**	**Possible contraindications to any vaccines/malaria prophylaxis:**

(7) IMMUNISATIONS

BCG date:	MMR dates:	Last DTP:	Hep B dates:	Comments
	1.		1.	
			2.	
	2.	Booster	3.	
			4.	

Consider	Required	Vaccine	Dates given previously	Date given in Travel clinic	Batch No. site and signature
☐	☐	BCG Vaccine			
☐	☐	DTP (Diphtheria, Tetanus, Polio)			
☐	☐	Hepatitis A Primary/Booster			
☐	☐	Typhoid			
☐	☐	Meningitis ACWY			
☐	☐	Rabies 1st			
☐	☐	Rabies 2nd			
☐	☐	Rabies 3rd			
☐	☐	Yellow Fever			
☐	☐	Japanese Encephalitis 1st			
☐	☐	Japanese Encephalitis 2nd			
☐	☐	Others			

(8) VACCINATION SCHEDULE

		Additional Vaccines/Requirements/Notes:	

(9) COMMENTS/ADDITIONAL INFORMATION

Date:		Signed:
Date:		Signed:
Date:		Signed:
Date:		Signed:

PATIENT CONSENT

I consent to this vaccine programme, and fully acknowledge that it is my responsibility to check on Rabies and HIV post-exposure treatment availability in relation to the elective upon which this risk assessment is based.

Patient Signature ..... Date .....

Nurse signature .....

Date of Risk assessment .....