# Travel Health Assessment Form – OHF5




## Travel Health Assessment Form

|  |  |  |  |
| --- | --- | --- | --- |
| Full Name |  | Date of Birth and Age |  |
| Place of Work |  | Contact Details |  |
| Male/Female |  | Staff/Student No |  |
| Date of Travel |  | Return Date |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Itinerary and purpose of visit/country to be visited | Duration | Risks/Hazards | Medical Facilities? |
|  | Type of Trip | Business | Pleasure | Other |
|  | Accommodation – give details | Hotel | Backpacking |  |
|  |  | Camping | Relatives/Family Homes |  |
|  |  | Trekking | Other |  |
|  | Travelling | Alone | With family/friend |  |
|  |  | In group | Other |  |
|  | Staying in area which is | Urban | Rural | Altitude |
|  | Planned Activities | Research | Health Care (Human) | Animal Centred |
|  |  | Other |  |  |

### Personal Medical History

|  |  |  |  |
| --- | --- | --- | --- |
| 1. Do you have any recent or past medical history of note? | **Yes** | **No** | Please give details: |
| 2. Are you taking any current or repeat medications? | **Yes** | **No** |  |
| 3. Do you have any allergies for example to eggs, antibiotics, nuts? | **Yes** | **No** |  |
| 4. Have you ever had a serious reaction to a vaccine given to you before? | **Yes** | **No** |  |
| 5. Does having an injection make you feel faint? | **Yes** | **No** |  |
| 6. Do you or any close family members have epilepsy? | **Yes** | **No** |  |
| 7. Do you have a history of mental illness including depression or anxiety? | **Yes** | **No** |  |
| 8. Have you recently undergone radiotherapy, chemotherapy or steroid treatment? | **Yes** | **No** |  |
| 9. Have you taken out travel insurance? | **Yes** | **No** | : |
| 10. If you have a medical condition have you informed the insurance company about this? | **Yes** | **No** |  |
| **11. Women only**: Are you pregnant or planning pregnancy or currently breast feeding**?** | **Yes** | **No** |  |

Vaccination History – Have you ever had any of the following vaccinations/malaria tablets? If so when?

|  |  |  |  |
| --- | --- | --- | --- |
| **Vaccine** | **Yes** | **No** | **Dates** |
| Diphtheria |  |  |  |
| Tetanus |  |  |  |
| Polio |  |  |  |
| MMR (measles, mumps, rubella) |  |  |  |
| Hepatitis A |  |  |  |
| Hepatitis B |  |  |  |
| Influenza |  |  |  |
| Tick Borne Encephalitis |  |  |  |
| Typhoid |  |  |  |
| Meningitis ACWY |  |  |  |
| Rabies |  |  |  |
| Japanese B Encephalitis |  |  |  |
| Yellow Fever |  |  |  |
| Tuberculosis (BCG) |  |  |  |
| Meningitis C |  |  |  |
| Cholera |  |  |  |
| Malaria Tablets |  |  |  |

Submit this form to the Occupational Health Unit - (occupational.health@ed.ac.uk), Drummond Street Annexe, Drummond Street, Edinburgh EH8 9XP - where an advisor will be able to discuss your needs with you and advise on actions you need to take.

**Recommendations**

The following immunisations, as follows, are recommended for your trip:

|  |  |  |  |
| --- | --- | --- | --- |
| **Vaccine** | **Route** | **OPAS updated** | **Sign** |
| Diphtheria |  |  |  |
| Tetanus |  |  |  |
| Polio |  |  |  |
| MMR (measles, mumps, rubella) |  |  |  |
| Hepatitis A |  |  |  |
| Hepatitis B |  |  |  |
| Influenza |  |  |  |
| Tick Borne Encephalitis |  |  |  |
| Typhoid |  |  |  |
| Meningitis ACWY |  |  |  |
| Rabies |  |  |  |
| Japanese B Encephalitis |  |  |  |
| Yellow Fever |  |  |  |
| Tuberculosis |  |  |  |
| Meningitis C |  |  |  |
| Cholera  |  |  |  |
| Malaria Tablets |  |  |  |

|  |
| --- |
| **Travel Advice and Leaflets given – to be completed by Occupational Health Advisor** |
| **Topic** | **Discussed** | **Queries** | **Sign** |
| Food, Water and Personal Hygiene |  |  |  |
| Travellers diarrhoea |  |  |  |
| Hepatitis B and HIV |  |  |  |
| Insect Bite Prevention |  |  |  |
| Animal Bites |  |  |  |
| Accidents |  |  |  |
| Insurance |  |  |  |
| Air Travel |  |  |  |
| Sun and Heat Protection |  |  |  |
| Websites |  |  |  |
| Travel Record Card Supplied |  |  |  |
| Travel Health Pack (Simple) |  |  |  |
| Sterile Health Pack + authorisation |  |  |  |
| Follow up programme |  |  |  |

**Malaria Prevention Advice and Malaria Chemoprophylaxis**

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication** | **Route** | **Supplied (number)** | **Sign** |
| Doxycycline |  |  |  |
| Chloroquine and Proguanil |  |  |  |
| Atovaquone and Proguanil (Malarone) |  |  |  |
| Chloroquine |  |  |  |
| Mefloquine |  |  |  |
|  |  |  |  |
| Malaria advice leaflet given |  |  |  |

**Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**