

## Border Practice Travel Vaccination Request

Please complete the following form and send to the surgery/hand to a receptionist, at least 4 weeks before your planned travel date.

Fields marked with \* are mandatory. A home telephone OR mobile number must be provided

Title \* \_\_\_\_\_

First Names \* \_\_\_\_\_

Surname \* \_\_\_\_\_

Date of Birth \* \_\_\_\_\_

Address \* \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Town \* \_\_\_\_\_

Post Code \* \_\_\_\_\_

Home Telephone \* \_\_\_\_\_

Mobile \* \_\_\_\_\_

Email \_\_\_\_\_

**Countries to be visited.** Please indicate places and lengths of stopovers.

Town	Country	Date	Approximate Length of Stay (days)

Reason for your Visit \_\_\_\_\_  
 If Business please briefly describe the type of work \_\_\_\_\_

Holiday / Business  
 \_\_\_\_\_

Will you be sleeping rough? Yes / No

Are you taking steroids? Yes / No

Are you taking any regular medicines Yes / No

Have you reacted badly to any previous vaccines? Yes / No

Are you allergic to any antibiotics? Yes / No

Are you on any other treatment? (e.g. cancer) Yes / No

Are you pregnant? Yes / No

Have you had a splenectomy? Yes / No

Please also list any vaccinations you have had over the last 10 years: (Type and Date)

\_\_\_\_\_

\_\_\_\_\_

Please return this form to The Border Practice, Blackwater Way, Aldershot, Hampshire, GU12 4DN