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: Holiday / Business
If Business please briefly describe the type of work _____

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

Office Use Only

Date	GP Name	I authorise the practice nursing staff to administer a vaccine or course of any of the above vaccines which are not covered by Hampshire PCT patient group directions	Signature