THE ROGERSTONE PRACTICE CHAPELWOOD
Please complete the front of the form only and return to Reception

Name: DOB:

Address:

Tel No: Patient No:

Holiday Destination ……

Date of Departure ……Date of Return……..

Length of Stay ……Are you staying in a holiday resort? YES/NO

Activity Holiday? e.g.(backpacking/golf etc) ……...

Are you febrile or suffering with an infection? ……...…

Receiving steroid /cancer treatment? ……...……

(if yes 'nurse' refer to 'immunisation against infectious disease')

HIV OR AIDS …… ('Nurse' to refer to as above)

Have you had a reaction to a previous vaccination? ……

Are you allergic to anything, especially eggs, antibiotics?……

Are you pregnant/breastfeeding? *(Ladies only*)……

Ladies only – Date of last period? …….……

Please give the name of any vaccines and the date you received them.
(Bring any record of previous vaccines with you when you attend)

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VACCINATION SCHEDULE: Nurse to complete

Recommended vaccinations **Doctors Signature:…….**

VACCINES		PREVIOUSLY RECEIVED? DATE GIVEN	NOW REQUIRED	Signature of Nurse	Date Given	FEE
Revaxis						
Viatim						
Adult Low Dose Diptheria & Tetanus						
	1st					
	2nd					
	3rd					
Booster	4th					
Booster	5th					
Polio						
Hepatitis A						
1st						
Booster						
6/12 months later						
Hepatitis B						
1st	Day 0					
2nd	One month					
3rd	6 months after 1st					
Blood test	3 months					
Fast Track						
Day 0						
1 Months						
2 Months						
12 Months						
Rabies						
0 days						YES
7 days						YES
28 days						YES
Typhim V1: every 3 years if remains at risk						
Malaria Tel: 01633 234233						
Yellow Fever **Refer patient to Bellevue surgery, advise polio to be given at the same time or allow at least 3 weeks between administration of live vaccines. Tel: 256337**						

OTHER ……..……

SIGNATURE OF PATIENT …… DATE: ……
PARENT IF CHILD UNDER 16 YEARS