

**Travel Health Plan Disclaimer:** Please ensure all relevant information is provided. Travelvax and its partner clinicians and agents shall not be liable for any advice or treatment provided based on incorrect or incomplete information.

PERSONAL DETAILS		
Surname:	First Name:	
D.O.B:	Telephone No:	
Address:	Postcode:	
Email:		
Employer:	Occupation:	
Medicare Number:		
Source of Referral:		
Emergency Contact:	Phone No:	Are you of Aboriginal or Torres Strait Islander decent? Y/N

TRAVEL & HEALTH PROFILE	YES	NO
Do you have a fever or illness at present?		
Have you been a patient in hospital in the last 6 weeks?		
Do you suffer from any disease e.g.; Diabetes, bleeding disorder, heart disease including heart rhythm disorders?		
Are you taking any medications? Please list:		
Have you received a blood transfusion or immunoglobulin in the past 12 months?		
Do you have HIV, an immune disorder or cancer? Have you had cancer treatment or chemotherapy?		
Have you been treated with steroids recently (e.g. Prednisolone)?		
Have you had any vaccinations in the last month?		
Do you suffer from any allergies? Please list:		
Have you ever had any reaction to a vaccination or are you allergic to latex or any preservatives in vaccines?		
Are you currently breast-feeding, pregnant or planning to become pregnant during your trip?		
Have you ever had hepatitis?		
Have you had a thymectomy, thymus disease, history of Myasthenia Gravis or DiGeorge syndrome?		
Have you had a splenectomy (spleen removed)?		
Have you ever been diagnosed with Guillain-Barre Syndrome?		
Have you ever had epilepsy or seizures?		
Have you required treatment for depression, anxiety or other psychiatric problems?		
Are you prone to heartburn, peptic ulcers or indigestion?		
Have you had any Achilles tendon problems?		
Have you ever had altitude sickness?		
Are you prone to thrush (candida)?		
Have you ever felt faint after an injection or giving blood?		
Are you especially scared of needles?		

INFORMATION ABOUT YOUR TRIP	
Reason for Travel:	
Departure Date:	Return Date:

COUNTRIES/REGIONS IN ORDER OF VISIT	DURATION: DAYS/WEEKS/MONTHS	TYPE OF ACCOMODATION TENT/HOSTEL/HOTEL/TRANSIT	ENVIRONMENT: URBAN/RURAL/ALTITUDE
1.			
2.			
3.			
4.			
5.			
Name of work site (if applicable)			

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

VACCINATION RECCOMENDATIONS					
VACCINE	CURRENT	ADMINISTER	DECLINED	RN SIGN	DATE ADMINISTERED / BATCH #
IPOV					
TETANUS / DIPHTHERIA					
dTpa – Adult					
dTpa IPV – Adult					
MMR					
CHICKENPOX					
HEP A - Adult					
HEP A - Paediatric					
HEP B - Adult					
HEP B - Paediatric					
TWINRIX - Adult					
TWINRIX - Paediatric					
TYPHOID - IM					
TYPHOID - Oral					
HEP A & TYPHOID					
CHOLERA					
YELLOW FEVER					
JAPANESE ENCEPHALITIS					
RABIES					
MENINGITIS ACWY					
MENINGITIS C					
INFLUENZA					

MALARIA			OTHER PRESCRIPTION MEDICATIONS		
IS MALARIA A RISK?	YES	NO	MALARIA SELF-TREATMENT	YES	NO
PERIOD OF EXPOSURE		DAYS	ALTITUDE PROPHYLAXIS	YES	NO
PROPHYLAXIS MEDICATION	ADMINISTER	QTY	TREATMENT MEDICATION	ADMINISTER	QTY
Doxycycline 100mg x 21 caps			Malarone 250mg x 12 tabs		
Doxycycline 100mg x 7 caps			Riamet 20mg +120mg x 24 tabs		
Malarone 250mg x 12 tabs			Diamox 250mg x 10 tabs		
Malarone 250mg x 1 tab			Norfloxacn 400mg x 6 tabs		
Malarone Junior 62.5mg x 12 tabs			Azithromycin 500mg x 3 tabs		
Malarone Junior 62.5mg x 1 tab			Fasigyn 500mg x 4 tabs		
Lariam 250mg x 8 tabs			Stemetil 5mg x 20 tabs		
COMMENTS:					

FIRST AID KITS RX KITS ACCESSORIES								
FIRST AID KITS			RX KITS			ACCESSORIES		
REC 1		PRO 1		RX 1/+		BED NET SG		REPEL Adult
REC 2		PRO 2		RX 2/+		BED NET DB		REPEL Junior
REC 3		PRO 3		RX 3/+		WATER FILTRATION DEVICE		MOSI-GUARD
OTHER								PERMETHRIN

<input type="checkbox"/> Mantoux PPD Tuberculosis Testing	
Date:	
Reading:	
Quantiferon Gold Result:	

REVIEW					
TRAVEL HEALTH EDUCATOR					
NAME		DESIGNATION		DATE	
MEDICAL PRACTITIONER					
NAME (print)		NAME (sign)		DATE	
FOLLOW-UP MEDICAL PRACTITIONER					
NAME (print)		NAME (sign)		DATE	
FOLLOW-UP MEDICAL PRACTITIONER					
NAME (print)		NAME (sign)		DATE	

DOCTOR OR NURSE TO COMPLETE					
HEALTH RISKS COVERED		LIVE VACCINE CHECKLIST		IMMUNOCOMPROMISED	
		YES	NO	YES	NO
Diarrhoea <input type="checkbox"/>	Schistosomiasis <input type="checkbox"/>	Egg allergy <input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy <input type="checkbox"/>	<input type="checkbox"/>
Safe eating/drinking <input type="checkbox"/>	High Altitude <input type="checkbox"/>	Pregnant / Discussed <input type="checkbox"/>	<input type="checkbox"/>	Immunosuppressed <input type="checkbox"/>	<input type="checkbox"/>
Malaria <input type="checkbox"/>	STIs <input type="checkbox"/>	HIV positive <input type="checkbox"/>	<input type="checkbox"/>	Infant contact <input type="checkbox"/>	<input type="checkbox"/>
Insect-borne <input type="checkbox"/>	Thrombosis <input type="checkbox"/>	Fever / illness <input type="checkbox"/>	<input type="checkbox"/>	Other <input type="checkbox"/>	<input type="checkbox"/>
Rabies <input type="checkbox"/>	Culture shock <input type="checkbox"/>	Steroids <input type="checkbox"/>	<input type="checkbox"/>	Contacts <input type="checkbox"/>	<input type="checkbox"/>
Comments:				Investigations and Vaccine Recall Details:	
Tropimed Report Given					

**VACCINE CONSENT**

With all vaccines there is a risk of adverse reactions. Serious allergic reactions are rare and generally occur within 30 minutes of vaccination. You may be required to wait on the premises for up to 30 minutes after vaccination for this reason. Less severe side effects may include:

- Localised tenderness, redness, swelling and irritation at the injection site.
- Mild fever and headache lasting a short period of time
- Mild gastrointestinal symptoms including abdominal pain and nausea
- More serious reaction are very rare, less than 1 in 10 000 injections

I have received information regarding the need for vaccination, contraindications to receiving vaccines, possible side effects and potential adverse reactions to the recommended vaccines, and I am consenting to receive the above listed vaccinations.

Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

**DECLARATION (CORPORATE REFERRALS ONLY)**

Please read the following and sign where indicated

**Declaration** - I declare that I have answered the above correctly and completely, to the best of my knowledge. I understand that any false or misleading information may result in disciplinary action, up to and including termination of employment.

**Statement authorisation** - I hereby authorise Sonic HealthPlus and the examining doctor to release any information acquired, collated or ascertained as a result of the examination and consultation to my employer, prospective employer or their authorised representative

I also acknowledge that the findings of this examination may be used by my employer, prospective employer or their authorised representative in relation to my employment.

Did you receive any assistance by another person to complete this form?  Yes  No

If Yes: provide details


Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

**OFFICE USE ONLY (FOR REQUESTING CORPORATE COMPANIES/CLIENTS ONLY)**

Assessment details	
<i>(Candidate name)</i>	
was assessed on	
proposed travel to	
Employed in position of	


**The following assessments have been completed and reviewed:**

	Satisfactory	Other	N/A		Satisfactory	Other	N/A
Medical History	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Audiometry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical examination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spirometry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug Screening has been completed (Only if specifically requested by employer)						Yes <input type="checkbox"/>	No <input type="checkbox"/>
Result of Drug Screen has been interpreted at the request of the client (Medical Review Officer Services)						Yes <input type="checkbox"/>	No <input type="checkbox"/>

<input type="checkbox"/>	Is <b>Fit</b> to safely travel to and work in the proposed location.
<input type="checkbox"/>	Is <b>Fit</b> to travel and to work in the proposed location with the following restrictions or comments:  
<input type="checkbox"/>	Is <b>Not Fit</b> to travel and to work in the proposed location
<input type="checkbox"/>	Requires further assessment / information before risk assessment can be completed. <input type="checkbox"/> Request for information sent to GP <input type="checkbox"/> Musculoskeletal / Fitness testing recommended <input type="checkbox"/> Other testing required (see below)

**Comments**


**Doctors Signature:**
**Date:**

Doctor / Clinic Stamp:

The examining doctor wishes to make it known that the purpose of this examination and the consequent opinions expressed are in the interests of prevention of occupational injury by the proper placement of employees in those positions best suited to their physical capabilities. This examination is not for the purpose of determining the success or otherwise of this person's application for employment.