Island Travel Clinic

Pre-Travel Risk Assessment Form (part 1) (to be completed by traveller)

Please complete ALL sections of this form prior to your appointment – one form per person.

1. PERSONAL DETAILS			
Name			
Address			
Date of Birth		Sex	☐ Male ☐ Female ☐ Nonbinary
Contact Number		Email	
GP name		GP practice	

2. DESTINATION			
Departure Date		Total Length of Trip	

Country	Region / Locations	Length of stay
1.		
2.		
3.		
4.		
5.		
6.		

Destination description (tick all that apply)

☐ main tourist spots	☐ coastal	☐ desert	☐ high altitude (over 2500 meters)
☐ towns/cities	☐ jungle	☐ remote	☐ countryside/villages

3. ACCOMMODATION (tick all that apply)			
☐ Hotel	☐ Tent / Camping	☐ Family /Friend's Home	Other (give details)
☐ Hostel	☐ Boat / Ship	☐ Homestay / AirBnB	

Will you have access to safe drinking water?	☐ Yes	☐ No
Will you have access to adequate sanitation (running water / toilets etc)?	☐ Yes	☐ No
Can you access a medical facility within 24 hours?	☐ Yes	☐ No

4. PURPOSE OF TRIP (tick all that apply)			
☐ Cruise	☐ All inclusive	☐ Hajj / Umrah	☐ Medical/Dental/Cosmetic treatment
☐ Package	☐ Mountaineering	☐ Pilgrimage	☐ Aid/ Emergency/relief work
☐ Business	☐ Hike /Trek	☐ Religious/Ceremonial	☐ Refugee camp
☐ Diving	☐ Cycling/Running	☐ Health Care Work	☐ Expedition – WITH GUIDE/SUPPORT
☐ Sailing	☐ Backpacking	☐ Contact Sport	☐ Expedition – NO GUIDE/SUPPORT
☐ Solo	☐ Group travel	☐ Self-Drive (Car/Bike)	☐ Other

Island Travel Clinic

Pre-Travel Risk Assessment Form (part 1) (to be completed by traveller)

5. INSURANCE		
Do you have adequate travel insurance cover for this trip?	☐ Yes	☐ No

6. MEDICAL DETAILS	YES	NO
Do you have any allergies including food (e.g. eggs, nuts etc.), medications, or latex?	☐	☐
Have you, or anyone in your family, ever had a severe reaction to a vaccine or malaria medication?	☐	☐
Do you tend to faint with injections?	☐	☐
Have you ever had any bleeding /clotting disorders (including history of DVT)?	☐	☐
Do you have, or have you ever had, any condition that could impair your immune system such as HIV/AIDS, blood cancer?	☐	☐
In the last 12 months, have you taken any medication or had any treatment that could impair your immune system e.g., chemotherapy, radiotherapy, high dose steroids, treatment with biologics?	☐	☐
Have you ever had any surgery including but not limited to: open-heart surgery, any kind of transplant surgery, spleen, or thymus gland removal?	☐	☐
Do you, or a first degree relative (parents, brother, sister, or child), have epilepsy or seizures?	☐	☐
Have you, or a first degree relative (parents, brother, sister, or child), ever experienced any mental health issues, even mild anxiety, or depression?	☐	☐
Are you or your partner pregnant, planning a pregnancy or have any reason to think you may be pregnant?	☐	☐
Are you breastfeeding?	☐	☐
Have you or anyone in your family undergone FGM / religious / ceremonial cutting	☐	☐
Are you receiving regular treatment from your GP or hospital specialist?	☐	☐
Are you waiting for any tests or medical investigations or treatment from you GP or specialist?	☐	☐
Do you have any disability or mobility problems?	☐	☐
Do you have any health conditions such as diabetes, heart, kidney, liver, respiratory (breathing) problems, neurological illness, blood disorders e.g., sickle cell disease, anaemia?	☐	☐
Are you taking any medications/injections/supplements including prescribed or not?	☐	☐

Further details If you answered yes to any of the questions above, please provide details here:

7. Applicant Declaration, Confidentiality Agreement and Personal Data Statement

I confirm that all the information I have given is correct. Where applicable I have no reason to think that I am pregnant.
Where vaccinations are given, I hereby give my consent. In respect of children under 16, I give my consent as their parent/legal guardian.
The information collected on this form will be held in accordance with the Data Protection (Jersey) Law 2018 and will be used by Island Medical Centre Partnership (hereafter the 'Practice') for the purposes of travel healthcare and related services and administration.
I am aware that personal data relating to myself, whether obtained from myself or from any other source, will be retained by the Practice for the purposes of providing me with travel healthcare and related services both inside and outside of the Practice.
I acknowledge that this may require my personal data to be forwarded to other persons for the purpose of referrals and for other lawful purposes related to the Practice procedures.
I hereby consent to the holding and disclosure of my personal data by the Practice for the purposes and in the manner set out above and accept that the Practice will not be liable for any subsequent release of my details to any unauthorised third party through any method beyond its control.
I understand that the Practice has the right to accept or decline this application.
I agree to pay all travel vaccination treatment given by the Practice at the time of treatment.

Signed:	Print Name:	Date: