**Travel Risk Assessment**

Please complete and return to the practice for the nursing team to review

**Please contact the surgery 6 - 8 weeks prior to your departure for your travel vaccination requirements**

|  |  |
| --- | --- |
| Name |  |
| Date of Birth |  |
| Address |  |
| Preferred Contact Number |  |
| Date of Travel |  |
| Length of Travel (days)  |  |
| Type of Holiday (please tick) | Backpacking / HostelsCruiseCampingHotelSafariOccupational |
| Which countries are you visiting?  |  |