PRE-TRAVEL RISK ASSESSMENT FORM

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TRAVELER NAME	GENDER	DATE OF BIRTH	DATE OF DEPARTURE	DATE OF RETURN
WILL YOU BE TRAVELING ALONE OR IN A	GROUP?			
PURPOSE OF TRAVEL				
WHAT ACTIVITIES OR EXCURSIONS DO YOU HAVE PLANNED?				
DESTINATION / ADEA OF TRAVEL	DUBATION OF STAV	LIVING ACCOMMODA	TION MODE(S)	OF TRANSPORTATION

DESTINATION / AREA OF TRAVEL in order of visit	DURATION OF STAY	LIVING ACCOMMODATION e.g. hotel, hostel, tent, family home	MODE(S) OF TRANSPORTATION

MEDICAL HISTORY

MEDICAL CONDITION(S) current and previous	
CURRENT MEDICATION(S) please list dosage and frequency	
ALLERGIES if any	
REACTIONS TO PREVIOUS VACCINES if any	
Have you recently had surgery?	
Have you previously taken malaria tablets? If so, please list the name of each.	
Please add any additional information you feel is relevant.	
Prior to making an app	pointment, please submit completed form to:

Please allow 48 hours after submitting this form to call to make an appointment at our office. Remember to bring an updated record of any vaccinations you have received to your appointment.

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