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| **OVERSEAS TRAVEL AUTHORISATION FORM**  **PART C – TRAVEL HEALTH ASSESSMENT** |
| **Reference Number:** |
| Health clearance is required by Occupational Health (OH) for:  It is also likely health clearance will be needed for:   * Travel to tropical countries and trips outside North West Europe and North America. * Fieldwork which involves working in remote areas (more than 24 hours away from medical support) ***or*** * Activities posing high risk in the event of sudden illness or incapacity e.g. technical climbing, abseiling, diving, caving ***or*** * A trip of more than 3 months duration.   The purpose is to identify any health needs you have and ensure that support is in place or can be provided for, in order to protect you and if applicable, other members of your team  Please answer the questions honestly and fully. The information you provide will be held in medical confidence.  If you have a health problem which could cause sudden illness or incapacity whilst away and for which you might require assistance from colleagues, your Fieldwork Leader or Supervisor will be advised on precautions which need to be in place to provide for this. Medical information will only be disclosed with your consent, and on a ‘need-to-know’ basis.  Our Line Manager and/or Fieldwork Leader or Supervisor will be informed of your fitness for travel.  You can check [www.fitfortravel.nhs.uk](http://www.fitfortravel.nhs.uk) for standard travel health information about vaccinations and malaria prophylaxis.  Please send your completed questionnaire to [occhealth@brookes.ac.uk](mailto:occhealth@brookes.ac.uk) The OH Administrator will contact you directly to set up an OH appointment if required.  The OH Administrator can be contacted on Ext: 5572 for further information. |

**HEALTH INFORMATION**

**CURRENT HEALTH – Please add in any FURTHER DETAILS as required:**

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| 1. Do you have any current health problems? | Yes: | No: |
| 1. Have you needed to consult a doctor in the past 6 months? | Yes: | No: |
| 1. Are you currently taking any medicines or treatment? (including non-prescribed medicines e.g. antacids, antihistamines, cough syrups etc)   If **Yes**, provide details (e.g. nature of problem; effects on you; treatment): | Yes: | No: |
| 1. Have you recently had surgery (within last 6 weeks) or imminent planned surgery or medical treatment? | Yes: | No |
| **FURTHER DETAILS:** |  |  |

**(Women Only)**

|  |  |  |
| --- | --- | --- |
| 1. Are you currently pregnant and have you consulted your GP about your intended travel? | Yes: | No: |

**PAST HEALTH**

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| 1. Have you ever had black-outs or a fit? | Yes: | No: |
| 1. Have you ever required emergency admission to hospital? | Yes: | No: |
| 1. Have you ever required specialist treatment or admission to hospital for a mental health problem? | Yes: | No: |
| 1. Have you been treated with steroid or immunosuppressant drugs in past 2 years? | Yes: | No: |
| 1. Have you ever had a bad reaction to a vaccine or injection? | Yes: | No: |
| 1. Have you ever had an allergic reaction to medicines or foodstuffs? | Yes: | No: |
| 1. Have you had a venous thrombosis (DVT)?   If **Yes**, provide details (e.g. nature of problem; when it occurred,  Consequences, treatment) etc. | Yes: | No: |
| 1. Have you ever suffered from a Tropical Disease?   If **Yes**, provide details (e.g. nature of problem; when it occurred, consequences; treatment) etc. | Yes: | No: |
| **FURTHER DETAILS:** |  |  |

**ADDITIONAL QUESTIONS**

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| 1. Do you have any health problem or disability that: 2. Affects your mobility? 3. Restricts your ability to undertake physically demanding tasks? 4. Renders you liable to injury? 5. Reduces your resistance to infection? 6. Impairs vision or hearing? 7. Requires special equipment or support to enable you to work independently? | Yes:  Yes:  Yes:  Yes:  Yes:  Yes: | No:  No:  No:  No:  No:  No: |
| 1. What time distance will you be from:    1. The nearest medical facility?    2. The nearest general hospital? | | |
| 1. Will you be working alone at any time? | Yes: | No: |
| If **Yes**, how far away from your base? | | |
| FURTHER DETAILS | | |

**IMMUNISATION HISTORY**

Have you been immunised against any of the following?

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| --- | --- | --- | --- | --- | --- | --- |
| **Vaccine** | **Date Last Vaccine** | **Date Next Vaccination Due** | **Vaccine** | **Date of Last Vaccine** | | **Date Next Vaccination Due** |
| Tetanus |  |  | Tuberculosis  (BCG) |  | |  |
| Polio |  |  | Hepatitis A |  | |  |
| Diphtheria |  |  | Hepatitis B |  | |  |
| Yellow Fever |  |  | Typhoid |  | |  |
| Rabies |  |  | Tick-borne encephalitis |  |  | | |
| Meningitis ACWY |  |  | Japanese encephalitis |  |  | | |

I confirm that I:

* Have been fully briefed on the measures identified to minimise the risks to my health and safety and will comply with the measures identified in the documented programme and plan for the trip.

When overseas I will:

* Advise the person in charge of the trip of personal circumstances or restrictions that might affect my fitness or ability when overseas that may increase the risk of injury to my self or others.

I will inform OH of any:

* Ill health as a consequence of the trip.
* Infections disease contracted that is no endemic in the UK or contracted from hotel food or water.
* Treatment received whilst overseas (including blood transfusions).

**Signed: Date:**

**Send completed forms to:** [**occhealth@brookes.ac.uk**](mailto:occhealth@brookes.ac.uk)