



Ashby Health Centre

North Street
Ashby-de-la-Zouch
Leicestershire
LE65 1HU

Tel: 01530 414131
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www.ashbyhealthcentre.org.uk

Please read before completing.

- Please give us as much notice as you can before travelling as you may need more than 1 visit to the Travel Clinic to complete your course of vaccinations. If we receive your Pre-travel Health and Vaccination Assessment Form and Pre-travel Disclaimer Form within 8 weeks of travel, **we will try our best to accommodate you in our Travel Clinic but this may not be possible.**
- We need sufficient time to discuss your trip and requirements. The information included on your Pre-travel Health and Vaccination Form determines the length of your appointment in our Travel Clinic. If your itinerary changes before your appointment or you have failed to detail your itinerary completely, we may ask you to make a further appointment to complete the discussion about your trip.
- Please telephone the Health Centre to book your Travel Clinic appointment **2 working days after bringing in your completed forms.** This allows time for our Travel Clinic nurses to look through the information given on your form and calculate how long your appointment will need to be, along with any recommended vaccinations for the areas that you have detailed in your itinerary.
- **Booking your Travel Clinic appointment is your responsibility.**

Charges for Immunisations to Patients Travelling Abroad

This practice provides immunisations to patients for the purpose of travel abroad on the understanding that the cost of the vaccine and the fee for administration of the vaccine are paid for by the Health Authority.

Some vaccines are never provided free by the NHS. If, for any reason, the Health authority refuses to reimburse the Practice for the cost of the vaccine or pay the appropriate fee for administration of the vaccine the Practice would claim from the patient.

I have read the above and agree to be responsible for the fees of immunisations in the event of the Health Authority refusing to reimburse the Practice.

Signature of Patient _____

Name (in Capitals please) _____

Date _____