

Health declaration

Complete the health declaration:

Name	Personal number
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- Have you ever had a severe reaction to previous vaccinations that needed hospital care? Yes No

If yes, describe what vaccine and the kind of reaction: _____

- Do you any allergies that at some point have caused such severe reactions that you needed hospital care? Yes No

If yes, against what and describe what kind of reaction: _____

- Are you allergic to eggs? Yes No

- Do you have increased bleeding tendency due to disease or medication? Yes No

If yes, describe the disease or medication: _____

- Do you have an ongoing infection with fever? Yes No

- Are you pregnant? Yes No

Week of pregnancy: _____

- Have you received any other vaccine in the past 7 days? Yes No

If yes, what vaccine?: _____

Other information

To be completed if you will be vaccinated against covid-19, influenza or pneumococcal disease.

- Previously vaccinated against influenza? Yes Year?..... No
 Not applicable

- Previously vaccinated against pneumococcal disease? (bacteria that can cause pneumonia) Yes Year?..... No
 Not applicable

- Previously vaccinated against covid-19? Yes No
 Not applicable

If yes, number of doses: _____

.....
Date

.....
Signature

Fylls i av vårdpersonal:

Influensavaccin FluAD Tetra® 0,5 ml	Batchnr	Hö arm	Vä arm
Influensavaccin Vaxigrip Tetra® 0,5 ml	Batchnr	Hö arm	Vä arm
Pneumokockvaccin Pneumovax® 0,5 ml	Batchnr	Hö arm	Vä arm
Kikhostevaccin Boostrix® 0,5 ml	Batchnr	Hö arm	Vä arm
Kikhostevaccin Triaxis® 0,5 ml	Batchnr	Hö arm	Vä arm
Covidvaccin Comirnaty® 0,3ml Original BA4/5	Batchnr	Hö arm	Vä arm
Covidvaccin Nuvaxovid® 0,5ml	Batchnr	Hö arm	Vä arm
Vaccin:	Batchnr	Hö arm	Vä arm
Vaccin:	Batchnr	Hö arm	Vä arm
Ordinator:			
Vaccinator:			