region västerbotten

Health declaration

Complete the health declaration:

Name	Personal number

- 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

region västerbotten

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**
Kikhostevacccin Triaxis® 0,5 ml	**Batchnr**	**Hö arm**	**Vä arm**
Covidvaccin Comirnaty® 0,3ml	**Batchnr**	**Hö arm**	**Vä arm**
Vaccin:	**Batchnr**	**Hö arm**	**Vä arm**
Vaccin:	**Batchnr**	**Hö arm**	**Vä arm**
Vaccin:	**Batchnr**	**Hö arm**	**Vä arm**
Ordinatör:			
Vaccinatör:			