Folkhälsomyndigheten
PUBLIC HEALTH AGENCY OF SWEDEN

HEALTH DECLARATION - VACCINATION

Complete one health declaration per person och dose.

Vaccination date: _____

Personal ID number: _____

Name: _____

To be completed by the person to be vaccinated:

Have you ever had a severe reaction to previous vaccinations that needed hospital care?	Yes ☐	No ☐
Do you have any allergies that at some point have caused such severe reactions that you needed hospital care?	Yes ☐	No ☐
Do you have an increased bleeding tendency due to disease or medicine?	Yes ☐	No ☐
Are you pregnant?	Yes ☐	No ☐
Have your received any other vaccine in the past 28 days?	Yes ☐	No ☐

HÄLSODEKLARATION – VACCINATION (ENGELSKA). ARTIKELNUMMER:23077-1.
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