

Fill in this form before you are or your child is vaccinated

Name Personal identity no

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Do you or does your child have a chronic lung disease, chronic cardiovascular disease, chronic liver or kidney disease, serious diabetes, severely impaired defence against infection, continuous need for asthma medicine during the last three years, other serious illness that affects the respiratory system, extreme obesity?

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Are you or is your child allergic to egg/chicken protein?

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Are you or is your child allergic to mercury (thiomersal)?

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Are you or is your child allergic to preservatives (formaldehyde)?

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Are you or is your child allergic to the antibiotics gentamicin?

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Do you or does your child have an ongoing infection with a temperature of over 38 degrees centigrade?

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Have you had or has your child had a strong reaction to any vaccination previously, for instance, difficulty in breathing?

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Are you pregnant?

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Ordination av vaccination (kryssa i rutorna nedan vad som ordineras)

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 Ja

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 Nej

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Datum Namn

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 läkare

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 sjuksköterska

Uppgifter att fyllas i av vaccinatören

Pandemrix dos nr 1, im, batchnr

Vaccinationsdat.

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Injektionsställe

Hö Arm Ben Skinka
Vä

Pandemrix dos nr 2, im, batchnr

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Hö Arm Ben Skinka
Vä

Vaccination mot säsongsinfluensan, im/sc, batchnr

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Hö Arm Ben Skinka
Vä

Vaccination mot pneumokocker, im/sc, batchnr

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Hö Arm Ben Skinka
Vä

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Namn på vaccinatör

Vårdcentral/klinik/distriktssköterskemottagning eller motsvarande

Consent to vaccination of child person receiving care

Have you read the information above and do you consent to vaccination being given against:

Novel H1N1 flu

Seasonal flu

Pneumococcus

Date

Custodian's name/Guardian's name

Telephone number, home or mobile