

HEALTH DECLARATION - CHILD

Vaccination against influenza and pneumococcal infections

Complete one health declaration per person.
Applies to children/young people under 18 years of age.
Guardian's signature required.

Vaccination date _____

Personal ID number _____

Name _____

Is your child allergic to eggs?	<input type="radio"/> Yes	<input type="radio"/> No
Has your child ever had such a severe allergic reaction to anything else that it was necessary to seek medical care?	<input type="radio"/> Yes	<input type="radio"/> No
Has your child ever had a severe reaction to previous vaccinations?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child have haemophilia or any other bleeding disorder, for example, warfarin treatment?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child have any chronic disease or have they had their spleen removed?	<input type="radio"/> Yes	<input type="radio"/> No
If yes, does your child have:		
Chronic lung disease, including asthma?	<input type="radio"/> Yes	<input type="radio"/> No
Severe obesity (BMI>40)?	<input type="radio"/> Yes	<input type="radio"/> No
Neuromuscular disease (for example, MS)?	<input type="radio"/> Yes	<input type="radio"/> No
Chronic cardiovascular disease (not just raised blood pressure)?	<input type="radio"/> Yes	<input type="radio"/> No
Increased risk of infection? (For example, immunodeficiency, but also other conditions such as cancer or autoimmunity where the disease itself or the treatment involves an increased risk of infection)	<input type="radio"/> Yes	<input type="radio"/> No
Indication for vaccination with pneumococcal conjugate vaccine? (Impaired spleen function; Severely impaired immune defence due to disease or treatment, for example, organ transplant, cytostatic treatment or treatment with equivalent to >15 mg prednisolone/day, other strongly immunosuppressive medication or TNF inhibitor in combination with another immune-weakening treatment; Nephrotic syndrome; Cochlear implant; Cerebrospinal fluid leakage; Cystic fibrosis)	<input type="radio"/> Yes	<input type="radio"/> No
Chronic liver or kidney failure?	<input type="radio"/> Yes	<input type="radio"/> No
Diabetes mellitus?	<input type="radio"/> Yes	<input type="radio"/> No
Cerebral palsy/multiple disabilities?	<input type="radio"/> Yes	<input type="radio"/> No
Is your child pregnant?	<input type="radio"/> Yes	<input type="radio"/> No
If yes, how many weeks?		

I consent to my child being vaccinated. Yes No

Signature of guardian for a minor

Signature of guardian for a minor

Print name

Print name