

Health declaration - vaccination against COVID-19

Complete one (1) health declaration per person and dose. Applies to persons aged 18 and above.

Name:	Personal identity number:
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Vaccination date: _____

Before your COVID-19 vaccination, we ask that you answer the following questions:

	YES	NO
1. Have you ever had a severe reaction to a vaccination and required hospital care?		
2. Do you have any allergies that at some point have caused severe reactions for which you required hospital care?		
3. Do you have an increased bleeding tendency due to illness or medication?		
4. Have you been vaccinated against anything other than COVID-19 in the past 7 days?		
5. Do you have any blood-borne diseases?		
6. Are you pregnant?		

Completed by the vaccination clinic:

COVID-19 vaccine name:	Dose 1	Dose 2
Batch/lot number:		
Right arm	Left arm	Other injection site:
Comments:		
Vaccinator's name:	Signature:	
Care provider:	Clinic/unit	
Registered in MittVaccin		