Health declaration for vaccination against seasonal influenza

Before your influenza vaccination we would like you to answer the following questions:

1. Do you currently have any fever or an acute infection?  
   Yes  No

2. Have you had an allergic reaction to any previous influenza vaccination?  
   Yes  No

3. Are you allergic to eggs?  
   Yes  No

4. Are you taking any blood thinning medication?  
   Yes  No
   If yes, which one(s)? ________________________________

If you wish to add any information, please do so here.

Information about the vaccination will be registered in the vaccination register Svevac. This means that healthcare staff can see that you have been vaccinated when you seek medical help and relevant authorities can follow up on the effect of vaccinations. You have the right to decline to have your information registered. If you wish to do so please inform the staff who carry out the vaccination. On our webpage www.regionkalmar.se you can read more about how we manage your personal data.

Date:........................................
Signature:......................................................

Box below to be filled out by healthcare staff /Fylls i av vårdpersonal

<table>
<thead>
<tr>
<th>Tilhör riskgrupp</th>
<th>Ja</th>
<th>Nej</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preparat</td>
<td>Influvac Tetra</td>
<td>Vaxigrip Tetra</td>
</tr>
<tr>
<td>Injektion given</td>
<td>Vä arm</td>
<td>Hö arm</td>
</tr>
<tr>
<td>Registrat i Svevac</td>
<td>Ja</td>
<td>Nej</td>
</tr>
</tbody>
</table>

Batchnummer: ______________________

Datum:........................................
Signatur:......................................................