SKOLHÄLSAN

Please fill in this form and bring it with you to the appointment with the school nurse

School	Class
First and last name	Social security number (10 digits)
Adress	Phone number
Mother's name	Cell phone number (mother)
Father's name	Cell phone number (father)

1. Do you regularly see a doctor, physiotherapist, optician or other specialist?

❑ No ❑ Yes For what? _____ Which specialist and where? _____

2. Do you take any medication regularly? ❑ No ❑ Yes

Which one? _____ Dose: _____ For what? _____

3. Have you had any notable disease since the health check-up in grade 6?

❑ No ❑ Yes

4. Have you had any vaccinations outside of school after grade 6?

❑ No ❑ Yes Which? _____ When? _____

5. The school health service's work includes providing guidance in choosing profession from a medical aspect. We would therefore like to know if you already have any plans for the future (regarding career)?

Programme at upper secondary school: _____Profession: _____

6. Do you smoke? ❑ No ❑ Yes **7. Do you use "snus"?** ❑ No ❑ Yes

8. Check the box if you have any of this:

❑ Asthma	❑ Troublesome tiredness	❑ Eczema	❑ Abdominal problems
❑ Eye disease	❑ Troublesome headaches	❑ Glasses	❑ Back problems
❑ Urinary problems	❑ Troublesome acne	❑ Anemia	❑ Hearing loss
❑ Allergy	❑ Other (write on the back)		

9. Is there anything in particular you would like to discuss with the school doctor? ❑ No ❑ Yes
Feel free to use the back of this form for any questions or comments.

_____ _____ _____

Date Student's signature Guardian's signature