VACCINATION PERMISSION

I give my consent to let my child

Name:______________________________ Social security number:___________________

School:____ Class:_______________

be vaccinated with Boostrix vaccine.

This vaccine is a booster vaccine to protect your child against diphtheria, tetanus and pertussis.

____
Date

____
Parent/guardian 1 signature

____
Clarification of signature

____
Parent/guardian 2 signature

____
Clarification of signature

____
Mobile phone

Address

Skolhälsan	**Telephone**	**Fax**	**E-mail**
Sollentunahälsan AB	**08-92 85 84**	**08-623 12 54**	**info@skolhalsan.se**
Tingsvägen 19, 4tr			
191 61 Sollentuna			