VACCINATION PERMISSION

I give my consent to let my child

Name:________________________ Social security number:_____________

School:_____________________________________ Class:_______________

be vaccinated with Imovax Polio vaccine.

This vaccine is given to prevent infections caused by polio virus.

____

Date

____

Parent/guardian signature

____

Clarification of signature

____

Mobile phone

Address
Skolhälsan
Sollentunahälsan AB
Tingsvägen 19, 4tr
191 61 Sollentuna

Telephone
08-92 85 84

Fax
08-623 12 54

E-mail
info@skolhalsan.se