



VACCINATION PERMISSION

I give my consent to let my child

Name: _____ **Social security number:** _____

School: _____ **Class:** _____

be vaccinated against MMR with Priorix.

This vaccine protects your child from measles, mumps and rubella.

Has your child been given any vaccinations in the past month?

Yes No **If yes, which:** _____

Does your child suffer from severe allergy, long term disease or is he/she taking any medications on a regular basis?

Yes No **If yes, which:** _____

Has your child been given any vaccine against

If yes, which year:

Measles Yes No

Mumps Yes No

Rubella Yes No

Has your child suffered from any of the following diseases?

If yes, which year:

Measles Yes No

Mumps Yes No

Rubella Yes No

Parent/guardian 1 signature

Mobile phone

Clarification of signature

Date

Parent/guardian 2 signature

Mobile phone

Clarification of signature

Date

Address

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