Self-declaration form - Vaccination

Surname:	First name:	Social security number:	
E-mail:	Mobile:	Nationality:	Employee no:
Manager:	Company:	Project:	
Date of departure:	Duration of trip:	Purpose of travel:	
Travel destination:			

Allergies: Please tick off if you have or have had:
☐ Severe allergic reaction
☐ Mild/moderate allergic reaction
☐ Egg allergy
☐ Cross allergy
If yes, please describe:

Previous vaccinations: Please tick off if you have:
☐ Completed child vaccination program in Norway
☐ Completed vaccination program in military service, date:

☐ Other vaccines, enter the type and dates:

Disease: Please tick off if you have or have had:
☐ Heart disease
☐ Cancer
☐ Depression or other mental disease
☐ Asthma / pulmonic disease
☐ Blood disease
If yes, please describe:

☐ Thrombosis
☐ Weakened immune system
☐ Splenectomy
☐ Diabetes
☐ Rheumatoid arthritis
☐ Other

Medication: Do you use one or more of the following types of medications:
☐ Marevan/Coumedin
☐ Cortisone
☐ Other Immunosuppressive medication
☐ Other medication, please describe:

☐ Epileptic medication
☐ Birth control pills
☐ Chemotherapy
☐ Medication that reduce stomach acid

Malaria / Tropical disease: tick off if you:
☐ Have previously used Malaria prophylaxis
☐ Have had Malaria disease
☐ Have had other tropical disease
If yes, please describe:

For women: Please tick off if the following applies to you:
☐ Are planning a pregnancy in the next three months
☐ Are breastfeeding
☐ Are pregnant, if yes please note the week no:

Do you allow that the Institute of Public Health is informed about which vaccines you received from us? The vaccines will be registered in a public database.
Yes ☐ No ☐

If needed, do you allow your relatives and employer to get information regarding which vaccines and/or malaria prophylaxis you've got?

Yes ☐ No ☐

Place and date:

Signature:

Please note that there is an observation time of 20 min after vaccination

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For Healthcare Professionals:

Vaccines	Dosage:	Date:	Date:	Date:	Date:	Date:
Polio						
Diphtheria/Tetanus						
Diphtheria/Tetanus/Pertussis/Polio						
Hepatitis, adult						
Hepatitis A, child						
Hepatitis B, adult						
Hepatitis B, child						
Twinrix, Hep A+B, adult						
Twinrix, Hep A+B, child						
Yellow fever						
Typhoid, Salmonella						
Japanese Encephalitis						
Meningococcus C						
TBE						
HPV						
Varicella						
Meningococcus ACWY						
Rabies						
Cholera/Echoral, tourist diarrhea						
Malaria prescription						
MMR						
Pneumovax						
Influenza vaccine						
tuberculosis Test						
BCG vaccine						
Blood sample						
Other information						