Region Kalmar län

Consent and offer of COVID-19 vaccination

Children and adolescents typically experience mild symptoms from COVID-19. However, children who become ill with COVID-19 can suffer from a rare but serious form of hyper-inflammation and may also experience long-term symptoms, such as loss of taste and smell, after recovering from the illness.

The Public Health Agency of Sweden has therefore decided that young people aged 12 and up should receive a COVID-19 vaccination.

The European Medicines Agency (EMA) safety review has shown that the vaccine is safe and effective for children aged 12 years and up. The vaccine is given in two doses.

You need to provide your consent for your child to receive the vaccination

You can provide your consent for your child to be vaccinated by ticking the box below.

If you, as a guardian, indicate that you do not consent to the vaccination of your child or if this consent form is not submitted, your child can not be vaccinated. If your child wishes to be vaccinated and is assessed to have reached a level of maturity where such a decision can be made without a guardian, he or she can consent to receive the vaccination.

Child's name: ……

Child's personal identity number:

……

Telephone number for guardian……

☐ Yes, I provide my consent for my child to receive the COVID-19 vaccine.

☐ No, I do not consent for my child to receive the COVID-19 vaccine.

Signatures

Place: …….... Date: ……

Guardian's signature: ……

Guardian's name, printed: ……

Guardian's signature: ……

Guardian's name, printed: ……

In the case of joint custody, both guardians' signatures are required.

☐ I have sole custody.

Important! Your child must bring this consent form to the vaccination; otherwise the vaccination cannot be administered. Exceptions can be made through a maturity assessment.

Document version: Version 1, 09/12/2021

Region Kalmar län

Health declaration – COVID-19 vaccination

Fill in one health declaration for each person; applies to persons 12 years of age and older.

Name:	Personal identity number:

Before you receive your COVID-19 vaccination, we ask you to answer the following questions:

	YES	NO
1. Have you ever had a severe reaction to a vaccination for which you to needed to be cared for in hospital?		
2. Do you have any allergies that have caused severe reactions for which you needed to be cared for in hospital?		
3. Do you have an increased tendency to bleed due to an illness or medication?		
4. Are you pregnant?		
5. Have you received a vaccine for anything other than COVID-19 in the last 7 days?		

To be filled in by the vaccination clinic:

COVID-19 vaccine name:					**Dose 1**		**Dose**	
Batch/lot number:							
Right arm		Left arm		Other administration site:			
Comments:							
Name of person administering the vaccine:					Signature:		
Healthcare provider:				Clinic/unit			
Registered in Mitt Vaccin							