

Personal identity number: _____

Name: _____

Address: _____

Child's legal guardian:

Name: _____

Tel. home: _____

Other tel. no.: _____

Poss. E-mail: _____

HEALTH DECLARATION To you as parent

- | | Yes | No | | | | | | | | | | | | |
|--|--------------------------|--------------------------|--------|-------|-------|-------|-------|-------|-------|-------|-------|-------|--|--|
| 1. Do you need an interpreter in your contacts with the medical services?
If Yes, what language do you speak? _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | |
| 2. Is your child healthy? (Apart from the reason for the operation) | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | |
| 3. Has your child had any serious illness?
(<i>E.g. Heart disease, diabetes, asthma, kidney disease, liver disease, seizures</i>)
If Yes, which? _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | |
| 4. Does your child have problems with their air pipes? Coughing? Croup? _____
Comments? _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | |
| 5. Does your child take any regular medication or has the child taken medication in the past 2 months? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | |
| <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 40%; text-align: left;">Name of medication</th> <th style="width: 20%; text-align: left;">Strength</th> <th style="width: 40%; text-align: left;">Dosage</th> </tr> </thead> <tbody> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table> <p>(please enclose a list of medications if appropriate)</p> | Name of medication | Strength | Dosage | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | | |
| Name of medication | Strength | Dosage | | | | | | | | | | | | |
| _____ | _____ | _____ | | | | | | | | | | | | |
| _____ | _____ | _____ | | | | | | | | | | | | |
| _____ | _____ | _____ | | | | | | | | | | | | |
| 6. Has your child previously had a general anaesthetic and/or had an operation?
If Yes – when, for what and at which hospital?
_____ | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | |
| 7. Has your child, you or anyone in your family had any problems in connection with general anaesthetic? If Yes – what? _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | |
| 8. Is your child allergic/hypersensitive
If Yes, to what? _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | |
| 9. Does your child easily feel nausea? (<i>Travel sick? After any previous operation?</i>) | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | |
| 10. Does your child have any loose teeth? _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | |

Please turn over!

- | | Yes | No |
|--|--------------------------|--------------------------|
| 11. Does your child have glasses/contact lenses? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Does your child have any body piercing? If yes - where? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Has your child received medical attention abroad or care at another hospital in Sweden in the past year, if so where and when? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Is there anything else you want to tell us or ask us about? | <input type="checkbox"/> | <input type="checkbox"/> |

The child's height _____ cm The child's weight ____ kg

Date

The parent's signature