Karolinska Institutet

Health certificate

Please read the health certificate information for health care providers before completing this form.

Applies to all students attending a placement on a healthcare programme within Stockholm County Council (Region Stockholm), or services that have an agreement with Stockholm County Council.

This health certificate must be **completed and signed by a licensed physician and presented (printed original copy) at the clinical placement.**

Student information

First name: Last name:

Date of birth (month/day/year): Country of origin:

Phone number: Email:

University / educational institution in Sweden:

Check all that apply:

Tuberculosis (TB) assessment (required)

Previous TB treatment or LTBI diagnosis? Yes No
If yes, a recent negative chest x-ray is required.

TB exposure* (origin, trip, family, friends?) Yes No
**If during the past 5 years lived in a high TB burden country (see separate list of countries) for more than 3 months or family member or other close contact with tuberculosis, a recent tuberculin skin test, TST (PPD) or IGRA (QuantiFERON) test is required.*

Negative TB Test (TST/IGRA) ☐

If tested, a copy of test result and screening date are required.

Screening date: _____

In case of a positive test result, a chest X-Ray is required.

Negative Chest-X-ray ☐

Copy of written X-ray report and screening date are required.

Screening date: _____

Symptoms of TB? (long-lasting cough, fever night sweats, weight loss)?

Yes No

If yes, referral to an infection clinic for diagnosis and treatment is required.

If answered YES to any of the questions above and/or undergone screening with TB-test or chest-X-ray, the student must visit Student Wellbeing Centre, KI, upon arrival to Sweden.

For contact information visit https://education.ki.se/welcome-to-student-wellbeing-centre

Immunization coverage

Hepatitis B

Vaccinated: yes □ no □

Varicella (Chickenpox)

Vaccinated / had disease: yes□ no □

Measles

Vaccinated / had disease: yes □ no □

Diphtheria

Vaccinated: yes□ no □

Covid-19

Vaccinated, doses: yes□ no □

Does the student have any wounds, eczema, or damaged skin?
yes□ no□

Comments:

This form was completed by:

Print name of licensed physician:

Street address:

City:

Country & Postal (Zip) code:

Medical stamp:

_____ _____

Date (month/day/year) Signature, physician.