Health clearance

Please advise the health clearance instruction 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 clearance must be **completed and signed by a licensed physician and presented (printed original copy) to the clinic of 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) clearance (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 country outside Western Europe/North America/Australia 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 is 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 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 screening with TB-test or chest-X-ray, the student must visit Student Wellbeing Centre, KI, upon arrival to Sweden, for further clearance. For contact information visit
https://education.ki.se/welcome-to-student-wellbeing-centre

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