Health clearance

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 to the clinic of placement.**

Student information

First name: Last name:
Date of birth (month/day/year): Country of origin:
Phone number: Email:

School / educational institution in Sweden:
Address in Sweden (incl. C/O address):

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.

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.

TB exposure* (origin, trip, family, friends?) Yes No
**If during the last 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) ☐
Copy of test result and screening date is required. Screening date: _____
In case of 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: _____

If answer YES to any question above and/or performed TB-test/chest-X-ray the student must contact The Student Health Centre, KI, for further clearance, before clinical placement. For contact information visit www.ki.se/studenthealthcentre

Karolinska Institutet

Student information

First name: Last name:
Date of birth (month/day/year): Country of origin:
Phone number: Email:

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: Medical stamp:
Street address:
City:
Country & Postal (Zip) code:

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

Student information

First name: Last name:
Date of birth (month/day/year): Country of origin:
Phone number: Email:

Section bellow will be filled by The Student Health Centre, if applicable

TB-screening cleared from The Student Health Centre, KI yes☐

Signature: date:

MRSA test at The Student Health Centre, KI yes☐

Signature: date: