Bilaga 1

Health declaration

Date: _____

Name: _____ Personal ID/ Date of birth:_____ - _____

1. **Do you have one or more of the following symptoms? (*Mark all boxes that apply*)**

   ☐ Cough for more than 2 weeks? ☐ Fever? ☐ Involuntary weight loss? ☐ Night sweat
   ☐ No, I have not had any of these symptoms

2. **Have you had tuberculosis yourself?**

   ☐ Yes
   ☐ No
   ☐ Don't know

3. **Do you have any relatives or other close contacts with confirmed or suspected tuberculosis?**

   ☐ Yes **[If yes]**, who and when:_____
   ☐ No
   ☐ Don't know

4. **In what country were you born?** _____

5. **Have you stayed for more than 3 months in any country outside Western Europe/North America/Australia?**
   ☐ Yes **[If yes]**, in which country and for how long?_____
   ☐ No

6. **Have you during the last 6 months…**
   a. worked, practiced or, as an inpatient got health care, outside the Nordic countries in any kind of health facility or had advanced outpatient treatment such as dialysis, surgery or wound care? ☐ Yes ☐ No

   b. visited high-endemic areas for multidrug-resistant bacteria: Asia, Africa, Middle East, Latin America during more than 2 months or have you got ongoing skin infection or wound originating from such visit, regardless of time spent? ☐ Yes ☐ No

7. **Do you, or anyone in your household, a known carriage of MRSA?**
   ☐ Yes ☐ No ☐ Don't know

8. **Have you had measles?**
   ☐ Yes ☐ No ☐ Don't know

9. **Are you vaccinated against measles?**
   ☐ Yes ☐ No ☐ Don't know

I declare that the information given in the health declaration above is complete and genuine.

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Date	Signature	Printed