CERTIFICATE

I, the parent _____

(First name and surname)

My phone: _____

I confirm with this document that my child _____

(First name and surname)

☐ **Does not suffer from chronic diseases**

☐ **Suffers from the following chronic diseases:**

1.
2.
3.

☐ **Does not take any medications on a daily basis**

☐ **Takes the following medications on a daily basis:**

1.
2.
3.

☐ **Is not allergic to medications, foods or other allergens**

☐ **Is allergic to the following medications, foods or other allergens (incl. inhaled substances):**

1.
2.
3.

☐ **Has been vaccinated in accordance with the current immunisation schedule**

☐ **Has not been vaccinated against the following diseases:**

- ☐ Tuberculosis
- ☐ Hepatitis B
- ☐ Diphtheria, tetanus, pertussis (whooping cough), polio
- ☐ Measles, mumps, rubella

☐ **Has been vaccinated against tick-borne encephalitis**

☐ **Has not been vaccinated against tick-borne encephalitis**

Date: _____

Signature: _____