Influenza vaccination pre-examination form for the erderly, etc.
高齢者等インフルエンザ予防接種予診票

※Please fil in or check ☑the box within the bold frame, The form will be scanned using AI-OCR, so please fill in carefully in block letters.

Address listed on resident registration card	**Iga City, Mie Prefecture**	phone number	( ) —
Name (katakana)	※Please fill out the form neatly in block script, left-justified, and count voiced consonants mark, If you cannot fit the entire form.Please fill out without taking a space.		
Name (kanji)			
Date of birth (Japanese calendar)	※Please check ☑ either「Taisho」「Showa」 ☐Taisho ☐Showa year month birth date (Age)	☐Male・	body temperature before examination degree ℃

Questions	Answer		医師記入欄
Have you read the instructions provided by your city or town regarding today's flu vaccination?	☐ yes	☐ no	
Do you understand the effects and side effects of today's vaccination?	☐ yes	☐ no	
Are you currently suffering from illness?	☐ yes	☐ no	
isease name ( )			
Are you receiving treatment (medication,etc.)	☐ yes	☐ no	
Did the doctor treating that illness aproved you to get vaccinated today?	☐ yes	☐ no	
Have you ever been diagnosed with an immunodeficiency?	☐ yes	☐ no	
Are you feeling unwell today?	☐ yes	☐ no	
Please write down the symptoms you are experiencing ( )			
Are you allergic to chicken meat or eggs?	☐ yes	☐ no	
Have you ever had a flu vaccination?	☐ yes	☐ no	
① Have you ever felt unwell at that time?	☐ yes	☐ no	
②Have you ever felt sick after receiving a vaccination other than influenza vaccination?	☐ yes	☐ no	
Have you ever had a seizure(convulsion)?	☐ yes	☐ no	
Have you received any vaccinasions within the past month? type of vaccination( )	☐ yes	☐ no	
Have you ever had a chronic illness such as heart disease,kidney disease,liver disease, or blood disorder? Disease name ( )	☐ yes	☐ no	
Did the doctor treating that illness aproved you to get today's vaccination?	☐ yes	☐ no	
Have you had a fever or been sick within the last month? Disease name ( )	☐ yes	☐ no	
Do you have questions about today's vaccinations?	☐ yes	☐ no	

医師記入欄		医師署名又は記名押印
	以上の問診及び診察の結果、今日の接種は(☐ 可能 ・ ☐ 見合わせる) 本人に対して、接種の効果、副反応及び予防接種健康被害救済制度について、説明した。	

Influenza Vaccination Request Form

After receiving a medical examination and explanation fro a doctor and understanding the effects and side effects of the vaccination, do you wish to receive the vaccinaton?

(☐ Yes, I would like to be vaccin ☐ No,I do not want to be vaccinated)

The porpose of this pre-examination form is to ensure the safety of the vaccination. I understand this and agree to submit pre-examination form to the city.

year month day personal signature (required) _____

(※If you unable to sign,have a proxy sign and state the proxy's name and relationship to the person being vaccinated)

医師記入欄	ワクチン名・ロット番号	接種量	実施場所・医師名・接種年月日
	シール貼付位置 ※枠に合わせてまっすぐに貼り付けてください (注)有効期限が切れていないか確認	0.50 ml	実施場所 医師名 医療機関等コード 接種年月日 ※記入例)4月1日→04月01日 2 0 2 ☐ 年 ☐☐ 月 ☐☐ 日

(医療機関等コード・接種年月日は枠内に収まるよう記入してください。)