Iga City Shingles Vaccination Pre-examination Form
伊賀市帯状疱疹予防接種予診票

1st dose（for fiscal year 2025）

※Please fil in or check ☑the box within the bold frame. The form will be scanned using AI-OCR, so please fill out 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 the block script,feft-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）	※P lease check ☑ either 「Taisho」「Showa」 ☐Taisho ☐Showa　year　month　birth date　Age	☐male ☐Female	body temparature before examination　degree　°C

Questions	Answer		医師記入欄
Have you read and understand "For those receiving the shingles vaccination"?	☐ yes	☐ no	
Do you understand the effects and side effects of today's vaccinations?	☐ yes	☐ no	
Is today's shingles vaccination the first of the regular vaccinations?	☐ yes	☐ no	
Are you currently suffering from any illness? Disease name（　）	☐ yes	☐ no	
Are you receiving treatment (medication,etc.)?	☐ yes	☐ no	
Did your doctor aproved you to get vaccinated today?	☐ yes	☐ no	
Have you ever been diagnosed with an immunodeficiency?	☐ yes	☐ no	
Are you feeling unwell today? Symptoms（　）	☐ yes	☐ no	
Have you ever had skin rash or hives or felt unwell after taking medicine or eating food?	☐ yes	☐ no	
Have you ever become ill after receiving a vaccination? type of vaccination（　）	☐ yes	☐ no	
Have you ever had a seizure (convulsion)?	☐ yes	☐ no	
Have you received any vaccinations within the last month? Type of vaccination（　）	☐ yes	☐ no	
Have you ever suffered from any chronic illness such as heart disease,kidney disease,liver disease or blood disease? Disease name（　）	☐ yes	☐ no	
Did the doctor treating you for that illness aproved you to get vaccinated today?	☐ yes	☐ no	
Have you had a fever or been sick within the last month? Disease name（　）	☐ yes	☐ no	
Have you had a blood transfusion or gamma globulin injection within the last 6 months?	☐ yes	☐ no	
Do you have any 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	

Shingles Vaccination Request Form

After receiving a medical examination and explanation from a doctor and understanding the effects and side effects of the vaccination,Do you wish to receive the vacination?

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

The purpose of this pre-examination form is to ensure the safety of the vaccinati
I understand this and agree to submit this pre-examination form to the city

year　month　day　personal signature（required）＿＿＿＿＿＿

（※If you are unable to do so yourself,have a proxy to sign it and include 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・接種部位	接種量	実施場所・医師名・接種年月日
	シール貼付位置 (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
	※「生ワクチン」「不活化ワクチン」どちらかにチェック☑を入れてください。		
	☐ 生ワクチン　皮下注射（ 左 ・ 右 ）		
	☐ 不活化ワクチン 筋肉内注射（ 左 ・ 右 ）		

※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。

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