Iga City Shingles Vaccination Pre-examination

伊賀市帯状疱疹予防接種予診票

2nd dose
(for inactivated vaccines)

past vaccination history	1st dose vaccination	year month day	※Vaccination interval,confirmation required

Address listed on resident registration card	Iga City, Mie Prefecture	Phone number	( ) —
Name (katakana)	※Please fill out the form neatly in the 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 ☐Female	body temperature	□□ degree □ ℃

Question	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 vaccination?	☐ yes	☐ no	
Was the first shingles vaccination an inactivated vaccine (intramuscular injection)?	☐ 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 a skin rash or hives or felt unwell after taking medicine or eating food?	☐ yes	☐ no	
Have you ever become ill after receiving a vaccination? Types 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	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	医師署名又は記名押印

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 vaccination? (☐ Yes,I would like to be vaccinat ☐ No, I do not want to be vaccinated)

The purpose of this pre-examination form is to ensure the safety of the vaccination.

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 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	※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。
	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	医療機関等コード □□□□□□□□□□
	※2回目の接種は不活化ワクチンのみ定期接種の対象です。		医師名	接種年月日 ※記入例)4月1日→04月01日 2□2□年 □□月 □□日
	☑ 不活化ワクチン 筋肉内注射(左 ・ 右)			