**Iga City**

For City Submission

**For routine vaccination**

**Pneumococcal Vaccine Pre-examination Form for the Erderly**
**高齢者肺炎球菌ワクチン予防接種予診票**

① Regular vaccination recipients
② 60 years old orolder but younger than 65 years old
※Please check the implementation guidlines

※Please fill in the bold box

| | | | | |
|---|---|---|---|---|
| | | body temperature before examination | | Degree °C |
| Address | Iga City | Phone number | | |
| higarana | | Sex | Date of birth | Meiji・Taisho・Showa（please circle the era name） |
| recipient's name | | male / female | | year month day |
| | | | age | （ ）years old |

| Questions | Answer | | 医師記入欄 |
|---|---|---|---|
| Have you ever received a pneumococcal vaccination?<br>If you answered「yes」you are not eligible for this vaccination. | yes | no | |
| Have you read the city instructions about getting the pneumococcal vaccine today? | yes | no | |
| Do you understand the effects and side effects of today's vaccination? | yes | no | |
| Are you currently suffering from any illness><br>If「yes」, 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?<br>If「yes」、Please describe the specific symptoms（ ） | yes | no | |
| Have you ever suffered from any chronic illnesses such as heart disease,kidney disease, liver disease or blood disease?<br>If「yes」, Disease name（ ） | yes | no | |
| Did your doctor treating for that illness aproved you to get vaccinated today? | yes | no | |
| Have you had a fever or been sick within the last month?<br>If「yes」, Disease name（ ） | yes | no | |
| In the past month, has anyone close to you, such as a family member,had influenza,measles,wind flu,chickenpox,or mumps?<br>If「yes」, disease name（ ） | yes | no | |
| Have you received any vaccinations within the last month?<br>If「yes」, type of vaccination（ ） | yes | no | |
| Have you ever become ill after receiving a vaccination?<br>If「yes」, type of vaccination（ ） | yes | no | |
| Have you ever had a skin rash of hive of felt unwell after taking medicines or eating food? | yes | no | |
| Have you ever had a seizure? | yes | no | |
| If「yes」, Did you have a fever then? （ ）age | yes | no | |
| Have any close relatives become ill after receiving the vaccination? | yes | no | |
| Do you have questions about today's vaccination's | yes | no | |

| | |
|---|---|
| 医師記入欄 | 以上の問診及び診察の結果、今日の予防接種は **[ 可能 ・ 見合わせる ]**<br>本人に対して、予防接種の効果、目的、接種するワクチンの有益性および副反応、ならびに予防接種健康被害救済制度について、説明をした。 **医師署名または記名押印[ ]** |

Column to be filled out by the person（vaccinated person） （Please fill out this form after your doctor examined you and determined that you are eligible for vaccination.）
After receiving a medical examination and explanation from a doctor and understanding the effects and purpose of the vaccination, the benefits of the vaccine, and the possibility of serious side effects, do you wish to receive the vaccination?

**[ yes i wish ・ no, i don't want to ]**

The purpose of this pre-examination form is to ensure the safety of vaccinations,
understand this degree to submit this pre-examination form to the City or Town.

| | | | |
|---|---|---|---|
| **Date** | **Reiwa year month day** | | |
| **Personal signature （required）** | ※Please be sure to fill this out even if you have someone else to sign it. | **proxy's signature** | ※Please fill out only if you are unabe to sign in person.<br>（relationship： ） |

| | | | |
|---|---|---|---|
| ワクチン名<br>Lot.No. | （有効期限がきれてないか確認） | 実施場所<br>医師名 | |
| 接種量 | 0.5mL | | |
| 接種年月日 | 令和 年 月 日 | | |