Iga

COVID-19 vaccination pre-examination form for elderly people
高齢者新型コロナウイルス感染症予防接種予診票

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

Address listed on resident registration card	**Iga City, Mie Prefecture**	Phone number	( ) —
Name (katakana)	※Please fill out neatly in the block script, left-justified,and using only one consonant 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 °C

Questions	Answer	医師記入欄
Have you read the instructions distributed by your city or town regarding today's COVID-19 vaccination?	☐ yes ☐ no	
Did you understand the effects and side effects of today's vaccination?	☐ yes ☐ no	
Are you currently suffering from anu illness?	☐ yes ☐ no	
Disease name （ ）		
Are you receiving treatment (medication, etc.)?	☐ yes ☐ no	
Did your docotraproved you to get vaccnated today?	☐ yes ☐ no	
Are you feeling unwell today?	☐ yes ☐ no	
Please write down any symptoms that are bothering you.（ ）		
Have you ever had a skin rash or hives or felt unwell after taking medicine or eating food?	☐ yes ☐ no	
Have you ever received a COVID-19 vaccination?	☐ yes ☐ no	
①Have you ever felt unwell at that time?	☐ yes ☐ no	
②Have you ever felt unwell after receiving a vaccination other than COVID-19?	☐ yes ☐ no	
Have you ever had convulsion?	☐ yes ☐ no	
Have you received any vaccinations within the past few months? Type of vaccination（ ）	☐ yes ☐ no	
Have you ever suffered from any chronic illnesses such as heart disease,kidney disease,liver disease, or blood disease?	☐ yes ☐ no	
Disease name（ ）		
Did your doctor that treating your illness,aproved you to get vaccinated today?	☐ yes ☐ no	
Have you had a fever or been sick within the last month?	☐ yes ☐ no	
Disease name（ ）		
Do you have any question 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。	

COVID-19 Vaccination Request Form

After receiving a docotr's diagnosis and explanation, and understanding the effects fo the vacciantion, would you like to receive the vaccination? （ ☐ I would like to be vaccinated ☐ I do not want to receive vaccinations ）

The purpose of this per-examination form is to ensure the safety of the vaccinaton. With this understading, I agree to this pre-examination form being submitted to the city.

year month day personal signature (required)

(※if you are 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	筋肉内接種 ml	実施場所 医師名 ※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