# 2025 Influenza Pre-Vaccination Check Sheet for Senior Citizens

Minato City

SAMPLE : Not for fill in.

*The following questionnaire is a translation of the official Japanese form of Pre-Vaccination Screening Sheet for Influenza Vaccination. Please submit the Japanese form by referring to the following translation.

| | |
|---|---|
| Name<br>Address<br>[Customer code] | **Free of charge**<br>From (start date)<br>to (end date) |
| Name of person receiving vacc | Barcode for personal number]<br>[Personal number] |
| Date of birth ( years old) Gender | rcode for vaccination code, etc.]<br>[Vaccination code, etc.] |

Note: Your temperature will be measured at the medical institution. Fields to be entered by the doctor are marked with *.

Enter the necessary items in the section below outlined in bold, and circle one of the options in each answer field.

Body temperature before examination ℃

| Question | Answer field | | *To be entered by the doctor |
|---|---|---|---|
| 1 Have you ever received an influenza vaccination before? | No | Yes | |
| (1) Have you ever felt ill after receiving an influenza vaccination? | Yes | No | |
| (2) Have you ever felt ill after receiving a vaccination other than an influenza vaccination? | Yes | No | |
| 2 Have you read the notice from Minato City about the influenza vaccination you will receive today? | No | Yes | |
| 3 Do you understand the effect and side-effects of the vaccination you will receive today? | No | Yes | |
| 4 Do you feel ill in any way today?<br>If you feel ill, please state your symptoms here. ( ) | Yes | No | |
| 5 In the past month, have you experienced a fever or developed any illness?<br>Name of illness: ( ) | Yes | No | |
| 6 Do you have any chronic illnesses such as heart disease, kidney disease, liver disease or blood diseas | Yes | No | |
| Name of illness ( ) | | | |
| Have you been told by the doctor treating you for this illness that you can receive the vaccination today? | Yes | No | |
| 7 Do you currently have any other illnesses? Name of illness ( ) | Yes | No | |
| Are you receiving any treatment (such as steroids or other drugs)? | Yes | No | |
| Have you been told by the doctor treating you for this illness that you can receive the vaccination today? | Yes | No | |
| 8 Have you been diagnosed with immune deficiency? | Yes | No | |
| 9 Have you ever experienced convulsions? | Yes | No | |
| 10 Have you ever developed skin rashes or hives, or become ill, due to drugs or food products(chicken eggs, poultry(chicken))? | Yes | No | |
| 11 Have you received any vaccinations in the past month? Name of vaccination ( | Yes | No | |
| 12 Do you have any questions about the vaccination today? | Yes | No | |

**To be entered by the doctor***

As a result of the above interview and an examination, I have determined that today, a vaccination ( can be performed / should be deferred ).
I have explained the effects and side-effects of treatment, and the relief system for harm to health from vaccinations, to the person receiving the vaccination.

Doctor's signature or seal

**Request form for influenza vaccination (Please fill out this section only after the doctor has assessed that you can receive a vaccination based on the results of an examination.)**

I wish to receive a vaccination. I have received an examination and explanation from the doctor, and I understand the effects and side-effects of the vaccination.

The purpose of this pre-vaccination check sheet is to ensure the safety of vaccinations.
I understand this, and consent to this pre-vaccination check sheet and vaccination record being submitted to the Minato City Office.

Date: / /

Signature of person receiving vaccination

Signature of representative Relationship

(If the person receiving the vaccination is unable to sign, the representative should sign, and the name of the representative and the relationship between the representative and the person receiving the vaccination should be provided)

| Vaccine used | Dose of vaccine | Place of vaccination/name of vaccinating doctor/date of vaccination |
|---|---|---|
| Lot No. | 0.5 ml | Place of vaccination |
| Note: Check that it has not passed the expiry date | | Date of vaccination / / |

※注意 本予診票を用いて請求を行うことはできません。日本語の予診票に転記の上、請求を行ってください。