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

# FY2025 Pre-Vaccination check Sheet for Voluntary Influenza Vaccination for Children in Minato City

**Minato City Residents Only**

SAMPLE:Not for fill in.

| | | |
|---|---|---|
| Address | | *Subsidy of ¥4,500 per vaccination<br>*FluMist cannot be used for the second dose |
| Patient Name | | *The pre-vaccination sheet is valid from October 1 to January 31 of the following year. |
| Patient Date of Birth Year Month Day ( year(s) month(s) old) | Sex | Check applicable「✓」 ☐6 months to 13 years old<br>☐13 years old or over |

| | | | | | |
|---|---|---|---|---|---|
| Please choose either HA vaccine or FluMist.<br>「✓」to mark the box for the one of the vaccine and fill in the date of previous vaccination.(in the same fiscal year) if applicable.<br>*** HA vaccine:subcutaneous injection**<br>*** FluMist:nasal spray** | HA vaccine<br>*subcutaneous injection | ☐ First dose | ・For children aged 6 months to under 13 years who choose subcutaneous injection, the second dose will be subsidized even if they turn 13 years old before receiving it.<br>・13 years old who received the first vaccine before the age of 13. | FluMist<br>*nasal spray<br>Ages 2 and up | ☐First dose<br>FluMist is a covered vaccine since this year. Please check with your helthcare provider for your copayment amount. |
| | | ☐ Second dose | Previous HA vaccination (in the same fiscal year):<br>Year Month Day | | |

**Fill in the required items for the questions below, and circle an answer in the answer column** | Body temperature before screening . °C

| | Questions | Answers | | Doctor's Notes |
|---|---|---|---|---|
| 1 | Have you read the explanation about today's vaccination or received an explanation from the hospital and did you understand it? | No | Yes | |
| 2 | Child's development history — Were there any problems during delivery? | Yes | No | |
| | Birth weight ( ) grams — Were there any post-birth abnormalities? | Yes | No | |
| | During the patient checkups, have you ever been told that there was an abnormality? | Yes | No | |
| 3 | Is the patient feeling unwell today?<br>Describe their specific symptoms ( ) | Yes | No | |
| 4 | Has the patient been sick in the last month? Illness name ( ) | Yes | No | |
| 5 | Within the last month, has anyone in your family, or any of the patient's playmates been sick with measles, mumps, rubella, or chickenpox, etc.? Illness name ( ) | Yes | No | |
| 6 | Has the patient received a vaccine within the last month?<br>Vaccine name ( ) Vaccination date ( / ) | Yes | No | |
| 7 | Since birth and until now, has the patient been seeing a doctor for a congenital abnormality or a heart/kidney/liver/cranial nerve/immunodeficiency or other disease? Illness name ( ) | Yes | No | |
| | Have you been told by the doctor treating the patient that they can receive today's vaccination? | Yes | No | |
| 8 | Is the patient currently taking a special medication such as steroids(oral) or immunosuppressants? | Yes | No | |
| 9 | Has the patient ever had convulsions or spasms? ( ) years old | Yes | No | |
| | Did the patient has a fever at that time? | Yes | No | |
| 10 | Has the patient ever had a rash or hives on their skin, or felt unwell due to medicine or food (especially from chicken eggs/meat/gelatin) | Yes | No | |
| 11 | When administering FluMist<br>Is the patient pregnant, possibly pregnant, or breastfeeding? | Yes | No | |
| 12 | Do you have a close relative that has been diagnosed with a congenital immunodeficiency? | Yes | No | |
| 13 | Has the patient ever gotten sick after being vaccinated?<br>Vaccine name ( ) | Yes | No | |
| 14 | Have any of patient close relatives gotten sick after being vaccinated? | Yes | No | |
| 15 | Do you have any questions about how the patient is feeling today or about today's vaccine? | Yes | No | |

**Field for Doctors**

As a result of the above questions/examination, I have determined that today's vaccine (can be administered / should be postponed)

I have explained about the vaccine's effects, side effects, and the Relief System for Injury to Health with Vaccination to the parent or the individual receiving the vaccine (if age 16 or older).

**Doctor's Signature or Name Seal**

**[Field for Parents or Individual Receiving Vaccine (Self-Signed)] Place a「✓」in one of the below.**

☐If accompanied by a guardian or their agent (accompanying person)/if the vaccine recipient is age 16 or older

Before receiving the vaccination, I will be examined and explained by a doctor, and understand the effects and purpose of the vaccination, the possibility of serious side effects, whether or not I am eligible for relief under the " Adverse Drug Reaction Relief System" under the Pharmaceuticals and Medical Devices Agency Act, etc. I also understand that the purpose of this pre-screening sheet is to ensure the safety of vaccinations, and agree to this pre-screening sheet being submitted to Minato City.

Signature of guardian (if the vaccine recipient is age 16 or older, then the individual themself) or the accompanying person contact(phone number)

☐If the vaccine recipient is age 13 to 15 and not accompanied by a guardian

I have read the instructions for receiving the influenza vaccine, and understand the effects and purpose of the vaccination, the possibility of serious side effects, and cases in which relief is available under the " Adverse Drug Reaction Relief System" under the Pharmaceuticals and Medical Devices Agency Act, and I agree to receive the vaccination after taking into consideration the Patient medical history, health condition, and physical condition on the day of vaccination. I also understand that the purpose of this pre-screening sheet is to ensure the safety of the vaccination, and agree to this pre-screening sheet being submitted to Minato City.

Signature of guardian Emergency contact(phone number)

| Vaccine Used | | Administering Site / Name of Administering Doctor |
|---|---|---|
| Lot No.<br>Note: Confirm that the expiration date has not passed | | Name, Address, and Phone Number of Administering Institution |
| HA vaccine<br>*subcutaneous injection | ☐ 0.25 ml (6 months to 3 years)<br>☐ 0.5 ml | Name of Administering Doctor |
| FluMist<br>*nasal spray | ☐ 0.2 ml (Ages 2 and up)<br>Spray 0.1ml into each nostril | Vaccination (Pre-Screening) Date: Year Month Day |