Screening Questionnaire for Influenza HA Vaccine

For voluntary vaccination

This screening questionnaire cannot be used for routine vaccinations.
For routine vaccinations, the questionnaire provided by the municipal government should be used.

※ Please fill out information only within the 'bolded' frames if you wish to receive the vaccination. Please circle the appropriate one of the two options in the answer columns.
※ If a child is to be vaccinated, a parent/guardian who is familiar with the child's health condition should fill out the questionnaire.

Body temperature before examination				℃
Address			TEL ( ) -	
Name of the recipient		Male · Female	Date of birth	Day Month Year / / (Age: years months)
Name in English (if needed)				
(Name of the guardian)				

Questions	Answer		Doctor's Use
1. Have you read and understood the explanation about the flu shot (on the back) that you are about to receive today?	No	Yes	
2. Do you have any concerns about your health condition today?	Yes, please specify ( )	No	
3. Currently, are you under treatment by a doctor for any disease? Has the doctor told you if it is OK to receive the vaccination today?	Yes, Name of disease ( ) Yes/No/Haven't talked in particular.	No	
4. Have you been ill within the past month?	Yes, Name of disease ( )	No	
5. Do you have any significant past medical history to declare (any congenital anomaly, any disease of the heart, kidneys, liver or cranial nerves, any immunodeficiency, any blood dyscrasia, etc.)?	Yes, Name of disease ( )	No	
6. Have you ever experienced a skin rash/urticaria or felt ill after taking certain medications or eating certain foods (especially, egg, poultry, other poultry-derived foods)?	Yes Name of medication(s)/foods ( )	No	
7. Have you ever suffered from convulsions?	Yes (about episode[s]) (Date of the last episode: Around Month /Year)	No	
8. Have you ever been diagnosed as having a respiratory disease(s), such as interstitial pneumonia or bronchial asthma?	Yes	No	
9. Is the vaccine that you are about to receive today your first this season?	No, Date of the last vaccination (Day /Month)	Yes	
10. Have you ever felt unwell after receiving a flu shot?	Yes	No	
11. Have you ever felt unwell after receiving any vaccine other than a flu shot?	Yes, Name of vaccine ( )	No	
12. Have you received any vaccine within the past month?	Yes, Date of vaccination (Day /Month) Name of vaccine ( )	No	
13. Do you have any close relatives with congenital immunodeficiency?	Yes	No	
14. Has anyone among your close relatives or other contacts been diagnosed as having measles, rubella, varicella, mumps, etc., in the last month?	Yes Name of disease ( )	No	
15. [Females only] Are you currently pregnant?	Yes	No	
16. [If the person about to be vaccinated is a child] Were any abnormalities detected in the child during delivery, at birth, or during infant checkups? Birth weight ( ) g	Yes Please specify ( )	No	
17. Please specify any other concerns or questions you might have about your health condition that you want to share with the doctor.			

Doctor's Comments

Based on the above information and results of medical examination, I believe that today's vaccine (can be administered/should be postponed).
I have explained to the recipient/guardian about the effects of the vaccination, the possible adverse reactions, and the relief services available to the recipients for any adverse reactions, in accordance with the Pharmaceuticals and Medical Devices Agency Act.

Signature, or name and seal of the doctor

Patient/Guardian's Use

I (agree/disagree) to be vaccinated, after having undergone a medical checkup by the doctor, as well as received and understood the doctor's explanation about the vaccination and its effects and possible adverse reactions.

Signature (if you are a proxy: relationship to the vaccine recipient)

Note if the recipient is unable to sign the form, a proxy should sign it and indicate his/her relationship to the recipient.

Name of vaccine to be used	Dosage and Administration	Institution/Doctor's name/Date and time of vaccination
☐Influenza HA Vaccine "KMB" Lot No.: Medical record No.: (Seller: Meiji Seika Pharma Co., Ltd.)	Subcutaneous ☐0.5 mL (3 yrs. old and older) ☐0.25 mL (6 months to under 3 yrs. old)	Institution: Doctor's name: Date and time of vaccination: Hours : minutes , Day /Month /Year

Your provided personal information will be used only for the screening examination performed prior to the influenza vaccination.