Sample for	stuc	dents	Influenz	za Vaccination	Ques	stionn	aire				Please take your		
Please answer all items inside the bold frame.						Body temperature 3			6.9 ℃ ∠		temperture on the morning of the flu		
Name	Hanako Todai					Date of birth: 2000 ( Year / Month / Day )			/ <b>8</b> / <b>1</b> (Age: <b>19</b> )		vaccination and fill it in.		
Address	<b>〒27</b>	7-8540	5-O-O Kash	niwanoha, Kashiwa-shi, (	Chiba Pre	fecture		•					
Student ID No.	_	000000	Laboratory He	ealth laboratory	Staff	Affiliation	ı				Please fill in this field		
E-mail	_	000000	kor	(ext. 63040 ) hiwa@hc.u−tokyo.ac,			phone	000 - 1	(ext. )  234 - 5678	$\bigvee$	completely.		
Guardian's agreem	ont	I. ( Hanak	to Todai's mother	), agree that the a		tioned pers					Otherwise you will not be able to receive		
(if under 20)	ieric					Signatur	a C	ınae Todai			the vaccine.		
Questions							Ans	swers	Doctor's use				
Did you read the "Key Facts about Influenza (Flu) & Flu Vaccine" on the back of this sheet, an							YES	NO			If your age is under		
understand the efficacy and risks of the vaccine?  Are you currently going to a doctor for any sort of illness?							NO	YES			20,		
If yes,(Name of disease:							NO	VEC			we require your gardian's consent		
Are you receiving If yes, (Name of			tion, etc)?			)	NO	YES			and signature for you		
• • • •			s alright for you	to receive the influenza va	accination?		YES	NO			to receive your		
Are you feeling un						,	NO	YES		vaccination. Without your			
If yes, how? (				such as congenital abnorm	ality heart	) t kidnev					gardian's		
-	_			immune deficiency or any		-	NO	YES	\\		signature, you can not receive the		
(Name of a dis-						)	\/50		\	\	vaccine.		
Have you been sid				the flu vaccination?			YES	NO YES	<b>\</b>	$\sim$			
(indicate if any						)				\'	\		
-	-		, measles, rube	la, chickenpox, mumps or o	other infect	tious	NO	YES		\			
diseases in the las (indicate if any		tn?				)				\ \	\ \		
Have you received any vaccinations in the last month?						,	NO	YES			7		
(indicate if any						)				<i>\</i>	If you have not read		
Have you ever had (previous inject				(year/month))			YES	NO		the explanatory text,			
Did you become ill because of the vaccination?							NO	YES		you will not be given the vaccine. Please			
		after receivin	g a vaccination	? (Excluding the influenza v	accination		NO	YES			read the explanatory		
(indicate if any		sh hives or	other reaction t	o certain medicines or food	de	)					text on the other side		
(eggs or chicken		,					NO	YES		\	of the form.		
Details of medi						)							
Condition at th Any history of sei		e (	(	) Age Time		,	NO	YES					
If yes, did it co	me wit		`				NO	YES			Please fill in all		
		gnosed with i	nterstitial pneur	nonia, bronchial asthma, or	other type	es of	NO	YES			appropriate fields		
respiratory illness		relatives be	en diagnosed wi	th a congenital immunodefi	ciency?		NO	YES			accurately. Otherwise		
Do you have any							NO	YES			you may not be given the vaccine.		
Do you have any			ay's vaccination	?			NO	YES / mark assets		۱ ۱			
(Females only) A		-	vour receiving t	ne flu vaccination?			YES	YES / not sure NO	1				
, , , .			,	Vaccine recipier	nt:					, I ,			
I have answered the				standing the merits and risks		vaccine incl	uding the rare b	out severe adverse	e reactions.		If you choose to receive the vaccine,		
				factured in Japan]							please fill your		
						Signatur	e: Hana	ko Todai		1	signature.		
For doctor's use													
Tor doctor's use				医師記入欄						]			
以上の問診等の語	参察の	結果、今日の	の予防接種は	( 可能 · 見合わt	せる )。	•							
					医師の署	名又は記	名押印						
DATE 1 3	A -	L # P	+±1€.₽		_	2佐楼田 医4	TA 拉锤左口=			- ]			
ワクチンメーカー	<b>右</b> . ロツ	1. 倒写	接種量	宝饰探朗。 東京十学 / 2			师名.接種年月日						
メーカー名	実施機関: 東京大学 保健・健康推進本部   (皮下)   接種年月日: 20 年 月 日 医師名:												
Lot No.			(X I')	接種年月日: 20	年 月		医師名:						

Sample fo	r staff	Influenz	a Vaccination C	<b>Q</b> uestionr	naire			Please take your
Please answer all item		old frame		emperature	36.	9 °c	temperture on the morning of the flu	
Name		Hanako T	odai	Date	of birth : Nonth / Day)	1979 /	8 / 1 (Age: 40 )	vaccination and fill it in.
Address	〒277−8540	5-O-O Kash	iwanoha, Kashiwa-shi, Chil	a Prefecture	•	•		
Student ID No.		Laboratory	(ext. )	Departm	ent of Health	Please fill in this field completely.		
E-mail		kas	hiwa@hc.u-tokyo.ac.jp	ac.jp phone 000 - 123			234 - 5678	Otherwise you will not be able to receive
Guardian's agreeme	ent I, (		), agree that the above-	mentioned perso	n may receive	the influenza va	ccination.	the vaccine.
(if under 20)				Signatu	re:			
		Questions	An	swers	Doctor's use			
			Flu Vaccine" on the back of the	nis sheet, and	YES	NO -		If you have not read
understand the effi-		of the vaccine? or for any sort of illr	ness?		NO	YES		the explanatory text,
If yes,(Name of	-			)				you will not be given
Are you receiving t				,	NO	YES		the vaccine. Please read the explanatory
If yes, (Name of			to receive the influenza vacci	nation?	YES	NO		text on the other
Are you feeling unv			to receive the influenza vacci	nadon:	NO	YES		side of the form.
If yes, how? (				)				
-	nerve disease		such as congenital abnormality nmune deficiency or any other	NO	YES		Please fill in all appropriate fields	
		with you receiving t	he flu vaccination?	•	YES	NO		accurately.
Have you been sick	in the last mo	onth?		`	NO	YES		Otherwise you may not be given the
(indicate if any: Has anyone around diseases in the last		enza, measles, rubell	a, chickenpox, mumps or othe	NO	YES		vaccine.	
(indicate if any:			•	)	NO	VEO		
Have you received (indicate if any:	any vaccination	ons in the last month	1?	)	NO	YES		
Have you ever had (previous injection	on: 2	2018 / 11	(year/month))	YES	NO			
		the vaccination? eiving a vaccination?	(Excluding the influenza vaco	ination.)	NO	YES YES		
(indicate if any:				)				
		or other reaction to	certain medicines or foods		NO	YES		
(eggs or chicken e Details of medic				)				
Condition at tha				)				
Any history of seizu		(	) Age Time		NO	YES		
If yes, did it con		ith interstitial nneum	onia, bronchial asthma, or oth	er types of	NO	YES		
respiratory illnesses	-	icii incorocidai priodin	orna, pronomar accimia, or car	or types or	NO	YES		
	-		h a congenital immunodeficien	icy?	NO	YES		
		who felt ill following a today's vaccination?			NO	YES YES		
(Females only) Are					NO	YES / not sure		
-		to your receiving th	e flu vaccination?		YES	NO		
			Vaccine recipient:					1
I have answered the	questions above	e correctly and unders	tanding the merits and risks abou	ut this vaccine inc	luding the rare l	out severe adverse	reactions.	If you choose to
I still chose to receiv							<	receive the vaccine,
Influenza HA vaco	cination (quadriv	valent vaccine) [manuf	actured in Japan]	Signatu	re: Ha	nako To	odai	please fill your signature.
For doctor's use			医師記入欄		· · · · · · · · · · · · · · · · · · ·			1
以上の問診等の診	察の結果、今	日の予防接種は(		).				1
	maris 7	I WILKIEW (		 :師の署名又は覧	<b>夕押</b> 印			
			<u> </u>		- TO 17 H-	<del>, , , , , , , , , , , , , , , , , , , </del>		]
ワクチンメーカー名	ろ. ロット番号	接種量		実施機関. 医	師名. 接種年月日	l		
メーカー名		0. 5 mL	実施機関: 東京大学 保健・	健康推進本部				
Lot No.		(皮下)	接種年月日: 20 年	₣ 月 日	医師名:			
		l l						1