2024 Influenza Vaccination Questionnaire

Sample for Students

Please answer all items inside the bold frame.

Name	Hoken Hanako	Female / Male	Body temperature	36.3 ℃
			Date of birth : (Year / Month / Day)	2004 / 4 / 12 (Age: 20)
Address	〒277-8540 5-1-5 Kashiwanoha, Kashiwa-shi, Chiba			
Student	ID No. 99 - 000000 Laboratory Health Laboratory (Ext. 63040)	Staff	Affiliation (Ext.	
E-mail	hoken.hanako@××.u-tokyo.ac.jp		phone	090 - 0000 - 0000
Guardian's agreement (if under 18)	I, ( ), agree that the above-mentioned person may receive the influenza vaccination. Signature:			

Questions	Answers		Doctor's
Did you read the "Key Facts About Seasonal Flu Vaccine" , and understand the efficacy and risks of the vaccine?	YES	NO	
Is this your 1st influenza vaccination of this season?	YES	NO	
Are you feeling unwell at all today? If yes, how? (runny nose)	NO	YES	
Are you currently going to a doctor for any sort of illness? If yes,(Name of disease:)	NO	YES	
Are you receiving treatment (medication, etc)? If yes, (Name of medications:)	NO	YES	
Have you been ill within the past 1 month? (Name of illness:)	NO	YES	
Has anyone around you had influenza,measles, rubella, chickenpox, mumps or other infectious diseases within the past 1 month? (Name of a disease:)	NO	YES	
Have you received any vaccination within the past 1 month? (Name of vaccination:)	NO	YES	
Have you ever felt sick because of the influenza vaccination? (Symptom:)	NO	YES	
Have you ever felt sick after receiving a vaccination other than the influenza vaccination? (Name of vaccination: (Symptom:)	NO	YES	
Have you ever been diagnosed with a serious illness such as congenital abnormality, heart, kidney, liver, blood, central nerve disease, malignant tumor, immune deficiency or any other diseases? (Name of a disease:) If yes, does your doctor agree with you receiving the flu vaccination?	NO YES	YES NO	
Have you ever developed convulsion? about_____times The last time was about_____(year/ month) If yes, did it come with fever?	NO NO	YES YES	
Have you ever been diagnosed with interstitial pneumonia, bronchial asthma, or other types of respiratory illnesses?	NO	YES	
Have you ever had a rash, hives, or other reaction to certain medicines or foods (eggs or chicken etc.)? (Details of medicine and food:) (Condition at that time:)	NO	YES	
Do you have any close relatives who felt ill following a vaccination?	NO	YES	
Have you or any of your relatives been diagnosed with a congenital immunodeficiency?	NO	YES	
(Females only) Are you pregnant? If yes, does your doctor agree to your receiving the flu vaccination?	NO YES	YES / not sure NO	
If you have any questions that you want to tell the doctor about your health or today's vaccination, please write them here. ( )			

Vaccine recipient:

I have answered the questions above correctly and understanding the merits and risks about this vaccine, including the rare but severe adverse reactions.
I still chose to receive the influenza vaccination.
Influenza HA vaccination (quadrivalent vaccine) [manufactured in Japan]

Signature: Hoken Hanako

For doctor's use

医師記入欄

以上の問診等の診察の結果、今日の予防接種は （ 可能 ・ 見合わせる ）。

医師の署名又は記名押印_____

ワクチンメーカー名．ロット番号	接種量	実施機関．医師名．接種年月日
メーカー名 Lot No.	0．5 mL （皮下）	実施機関： 東京大学 保健・健康推進本部 接種年月日： 20 年 月 日 医師名：

Please take your temperture on the morning of the flu vaccination and fill it in.

Please fill in this field completely. Otherwise you will not be able to receive the vaccine.

If your age is *under 18*, we require your guardian's consent and signature for you to receive your vaccination. Without your gardian's signature, you can not receive the vaccine.

If you have not read the explanatory text, you will not be given the vaccine. Please read the explanatory text on the other side of this form.

Please fill in all appropriate fields accurately. Otherwise you may not be given the vaccine.

If you choose to receive the vaccine, please fill your signature.

2024 Influenza Vaccination Questionnaire

Sample for Staff

Please answer all items inside the bold frame.

Name	Hoken Hanako	(Female) / Male	Body temperature	36.4 ℃
			Date of birth : (Year / Month / Day)	1973 / 4 / 12 (Age:51)
Address	〒277-8540 5-1-5 Kashiwanoha, Kashiwa-shi, Chiba			
Student	ID No. – Laboratory (Ext.)	Staff	Affiliation	Health Laboratory (Ext. 63040
E-mail	hoken.hanako@××.u-tokyo.ac.jp		phone	090 - 0000 - 0000
Guardian's agreement (if under 18)	I, ( ), agree that the above-mentioned person may receive the influenza vaccination. Signature:			

Please take your temperture on the morning of the flu vaccination and fill it in.

Please fill in this field completely. Otherwise you will not be able to receive the vaccine.

Questions	Answers		Doctor's use
Did you read the "Key Facts About Seasonal Flu Vaccine" , and understand the efficacy and risks of the vaccine?	(YES)	NO	
Is this your 1st influenza vaccination of this season?	(YES)	NO	
Are you feeling unwell at all today? If yes, how? (runny nose)	NO	(YES)	
Are you currently going to a doctor for any sort of illness? If yes,(Name of disease:)	(NO)	YES	
Are you receiving treatment (medication, etc)? If yes, (Name of medications:)	NO	YES	
Have you been ill within the past 1 month? (Name of illness:)	(NO)	YES	
Has anyone around you had influenza, measles, rubella, chickenpox, mumps or other infectious diseases within the past 1 month? (Name of a disease:)	(NO)	YES	
Have you received any vaccination within the past 1 month? (Name of vaccination:)	(NO)	YES	
Have you ever felt sick because of the influenza vaccination? (Symptom:)	(NO)	YES	
Have you ever felt sick after receiving a vaccination other than the influenza vaccination? (Name of vaccination: (Symptom)	(NO)	YES	
Have you ever been diagnosed with a serious illness such as congenital abnormality, heart, kidney, liver, blood, central nerve disease, malignant tumor, immune deficiency or any other diseases? (Name of a disease:) If yes, does your doctor agree with you receiving the flu vaccination?	(NO) YES	YES NO	
Have you ever developed convulsion? about_____times The last time was about_____(year/ month) If yes, did it come with fever?	(NO) NO	YES YES	
Have you ever been diagnosed with interstitial pneumonia, bronchial asthma, or other types of respiratory illnesses?	(NO)	YES	
Have you ever had a rash, hives, or other reaction to certain medicines or foods (eggs or chicken etc.)? (Details of medicine and food:) (Condition at that time:)	(NO)	YES	
Do you have any close relatives who felt ill following a vaccination?	(NO)	YES	
Have you or any of your relatives been diagnosed with a congenital immunodeficiency?	(NO)	YES	
(Females only) Are you pregnant? If yes, does your doctor agree to your receiving the flu vaccination?	(NO) YES	YES / not sure NO	
If you have any questions that you want to tell the doctor about your health or today's vaccination, please write them here. ( )			

If you have not read the explanatory text, you will not be given the vaccine. Please read the explanatory text on the other side of this form.

Please fill in all appropriate fields accurately. Otherwise you may not be given the vaccine.

Vaccine recipient:

I have answered the questions above correctly and understanding the merits and risks about this vaccine, including the rare but severe adverse reactions.
I still chose to receive the influenza vaccination.
Influenza HA vaccination (quadrivalent vaccine) [manufactured in Japan]

Signature: Hoken Hanako

If you choose to receive the vaccine, please fill your signature.

For doctor's use

医師記入欄

以上の問診等の診察の結果、今日の予防接種は （ 可能 ・ 見合わせる ）。

医師の署名又は記名押印_____

ワクチンメーカー名. ロット番号	接種量	実施機関. 医師名. 接種年月日
メーカー名 Lot No.	0. 5 mL （皮下）	実施機関: 東京大学 保健・健康推進本部 接種年月日: 20 年 月 日 医師名: