			enza Vaccin	ation	Questi	onnaire						
Sample for Students Please answer all items inside the bold frame.						Body temperature		. 3 °c	Please take your temperture on the			
Name	Hoke	en Ha	anako	Female Male		of birth : Nonth / Day)	2004 /	4 /12 (Age:20	morning of the flu vaccination and fill it in.			
Address	〒 277-8540	5-1-5	Kashiwanol	ha, Ka	shiwa	-shi, Chi	ba					
Student ID No.	ID No. Laboratory Hoolth Laboratory Affiliati						(E	Please fill in this field completely. At. Otherwise you will				
E-mail		nako@>	×.u-tokyo.			phone		000 - 0000	not be able to receive the vaccine.			
Guardian's agr	eement ^{I, (}), agree that the a	above-menti	oned person	may receive th	e influenza vaco					
(if under 18	8)				Signatu	re:			your age is <i>under 18,</i> e require your			
		Questions				Ans	wers	Doctors	ardian's consent and gnature for you to			
	Did you read the "Key Facts About Seasonal Flu Vaccine" , and understand the efficacy and risks of the vaccine?							YES NO receiv vacciu				
-	influenza vaccination	of this season?				YES	NO	w	'ithout your gardian's			
Are you feeling If yes, how?	unwell at all today?	e)	NO	YES		gnature, you can not ceive the vaccine.			
Are you current	tly going to a doctor fo		ess?			NO	YES					
	e of disease: ing treatment (medicat e of medications:	tion, etc)?)	NO	YES		have not read the natory text, you will			
Have you been	ill within the past 1 m	onth?)	NO	YES	not be	e given the vaccine.			
Has anyone aro	(Name of illness: Has anyone around you had influenza,measles, rubella, chickenpox, mumps or other infectious diseases within the past 1 month?						YES	expla	ase read the lanatory text on the er side of this form.			
(Name of a o Have you receiv	nonth?)	NO	YES								
(Name of va	-)	NO	YES					
(Symptom:)			Please f				
Have you ever felt sick after receiving a vaccination other than the influenza vaccination? (Name of vaccination: (Symptom:						NO	YES	accurat	iate fields ely. se you may not			
Have you ever been diagnosed with a serious illness such as congenital abnormality, heart, kind liver, blood, central nerve disease, malignant tumor, immune deficiency or any other diseases						NO	YES		the vaccine.			
(Name of a o If yes, does	he flu vaccination?)	YES	NO								
Have you ever about		NO	YES									
If yes, did it	bout(year/ m		NO	YES		_						
Have you ever respiratory illne		nterstitial pneum	onia, bronchial asthma,	, or other typ	es of		YES					
Have you ever	[·] had a rash, hives, or o	other reaction to	certain medicines or f	foods		NO	YES					
-	nedicine and food:)							
(Condition a Do you have an	it that time: ny close relatives who	felt ill following a	a vaccination?)	NO	YES		-			
		en diagnosed witl	n a congenital immunoo	deficiency?		NO	YES		-			
-	Are you pregnant? your doctor agree to y	your receiving th	e flu vaccination?			YES	YES / not sure NO					
			ctor about your health	or today's v	accination, p	please write the	m here.		-			
()	lf	vou choose to			
			Vaccine rec			P 11 1 1		re	ceive the vaccine,			
	ceive the influenza vacc	-	anding the merits and risl	ks about this v	accine, inclui	ding the rare but	severe adverse re	sactions. ple sig	ease fill your nature.			
Influenza HA	vaccination (quadrivalent	t vaccine) [manufa	ctured in Japan]		Signatu	ire: Hok	en Ha					
For doctor's use				1 - 488					-			
 以上の問診等(の診察の結果、今日の)予防接種は(医師記刀 可能 • 見合:	<u>へ禰</u> わせる)	0				-			
		,			。 D署名又は言	记名押印			_			
ワクチンメーフ	カー名.ロット番号	接種量			実施機関. 医	師名. 接種年月日			7			
メーカー名		0. 5 mL (皮下)	実施機関:東京大学						1			
Lot No.			接種年月日: 20	年 月	日	医師名:						

2024 ****/ . **1**.

Comm		4 Influ	enza Vaccinat	ion (Questi	onnaire	2			Diagon taka yayır		
	e for Staff all items inside th	Body te	temperature 36.			°C	Please take your temperture on the morning of the flu					
Name	Hoke	n Ha	anako	Female Male		of birth : lonth / Day)	1973 /		/12	vaccination and fill it in.		
Address	〒 277-8540	5-1-5	Kashiwanoha	, Kas	shiwa-	-shi, Chi	iba					
udent ID No.										Please fill in this field completely. Otherwise you will		
E-mail	hoken.har	nako@×	X.u-tokyo.ac.j	p		phone				not be able to receive the vaccine.		
iuardian's agr), agree that the above		oned person	may receive th	ne influenza vaco	cination.		receive the vaccine.		
(if under 1					Signatur	re:						
		Questions				Ans	swers	Doct	or's use	1		
Did you read th	ne "Key Facts About S		cine″, and understand the	efficacy		YES						
	and risks of the vaccine? Is this your 1st influenza vaccination of this season?						NO		-	ou have not read the		
-	g unwell at all today?					YES NO	YES		-	anatory text, you will be given the vaccine.		
If yes, how?	tly going to a doctor fo)	NO	YES			se read the		
	e of disease:	or any sort of m	1635:)					anatory text on the er side of this form.		
-	ing treatment (medicat ie of medications:	tion, etc)?)	NO	YES					
Have you been	ill within the past 1 m	onth?			,	NO	YES			-		
(Name of ille Has anyone are		a measles ruhel	la, chickenpox, mumps or of	ther infe) ctious					4		
diseases within	the past 1 month?					NU	YES					
(Name of a Have you recei	disease: ived any vaccination w	ithin the past 1	month?)	NO	YES			-		
(Name of va	accination:)							
Have you ever (Symptom:	felt sick because of th	ne influenza vaco	ination?)	NO	YES		Please fi			
Have you ever		g a vaccination o	other than the influenza vac	cination	?	NO	YES		appropri accurate	ate fields		
(Name of va (Symptom	accination:)				Otherwis	se you may not		
Have you ever			such as congenital abnorma			NO	YES		be given	the vaccine.		
liver, blood, cer (Name of a		llignant tumor, in	mune deficiency or any oth	ner disea	ses?							
If yes, does	your doctor agree with		he flu vaccination?			YES	NO			_		
-	developed convulsion? times The		about(year/ month)		NO	YES					
If yes, did it	come with fever?					NO	YES			_		
Have you ever been diagnosed with interstitial pneumonia, bronchial asthma, or other types of respiratory illnesses?						NO	YES					
Have you ever	r had a rash, hives, or o	other reaction to	certain medicines or foods	6		NO	YES					
eggs or chick) (Details of r	en etc.)? nedicine and food:)							
(Condition a)					_		
Do you have any close relatives who felt ill following a vaccination? Have you or any of your relatives been diagnosed with a congenital immunodeficiency?						NO NO	YES YES			-		
(Females only) Are you pregnant?						NO	YES / not sure					
	your doctor agree to y		e flu vaccination? octor about your health or to	odovic v	pagination n	YES	NO			_		
			otor about your nearth of the	Juay S Va		isase write trie)		(cr	au chasas ta		
			Vaccine recipien	t:					• • •	ou choose to eive the vaccine,		
	-	-	anding the merits and risks ab		accine, includ	ing the rare but	severe adverse re	actions.	· · ·	ase fill your		
	eceive the influenza vacc vaccination (quadrivalent		ctured in Japan]			.	_			nature.		
		, <u>_</u>	, -		Signatu	re: Hok	en Ho	ınak	(0			
or doctor's use										-		
			医師記入欄	_						-		
以上の問診等の	の診察の結果、今日の)予防接種は(可能・見合わせ									
		T		医師の	署名又は記	名押印						
ワクチンメー	力一名. ロット番号	接種量			実施機関. 医的	币名. 接種年月日						
メーカー名		0.5 mL	実施機関: 東京大学 保健	<u></u> ∎•健康推	進本部				_			
Lot No.		(皮下)	接種年月日: 20 年	月	B	医師名:						