	202	5 Influ	enza Vacc	ination	Quest	ionna	ire			1		
Please answer all items inside the bold frame very Pencils or erasable pens are not allowed.			Sample for Students			Body temperature 36.				Please take your temperture on the morning of the flu		
Name	Hoken	Ha	nako	Female Male	Date	of birth: 2004/ Month / Day)			4 / (Age: 2	12	vaccination and fill it in.	
Address	₹277-8540 5 -1	l-5 Kas	hiwanoha	. Kashiv	va-shi.		Common II	12	3456789	l		
Student ID No. Laboratory Health Laboratory The Common ID is the 10 digit number printed on the bottom right hand corner of your ID Card. 共通IDとは(What is the Common ID?)/東京大学 保健センター												
E-mail	hoken.hana	ako@×	×.u-tokyo	ac.jp	<u>&(What is ti</u>			求人于 1 20 (休庭 ピンプ	_		
Guardian's agr), give my cor	nsent for the ind	lividual name	d above to	receive the	influenza	a vaccination		our age is under 18,	
(if under 1	8)				Signatu	ıre:			$\overline{}$	we	require your	
Questions							Answers Docto				ardian's consent and nature for you to	
Did you read the "Key Facts About Seasonal Flu Vaccine", and understand the efficacy						YES NO					ceive your ccination.	
	and risks of the vaccine? Is this your 1st influenza vaccination of this season?							NO			thout your gardian's	
Are you feeling unwell at all today?						YES NO	7 8			_	nature, you can not	
	If yes, please specify. (runny nose) Are you currently going to a doctor for any sort of illness?							(TC		rec	ceive the vaccine.	
	e specify. (Name of dis		iess?)	NO	ノ '	'ES				
Are you receivi	ing any treatment (med	ication, etc)?				NO	Y	'ES		-	have not read the natory text, you will	
If yes,please specify. (Name of medications: Have you been ill within the past 1 month?						NO		'ES		· -	e given the vaccine.	
If yes, please specify. (e read the	
Has anyone around you had influenza,measles, rubella, chickenpox, mumps or other infectious diseases within the past 1 month?						NO) \	'ES			natory text on the side of this form.	
If yes, please s	•)					Strick	side of this formi	
	ved any vaccination wit	thin the past 1	month?		`	NO)	'ES				
If yes, please specify. (Have you ever felt unwell after receiving a influenza vaccine?						NO	5	'ES		Please fill in all		
If yes, please specify the name of vaccination and symptoms. (opriate fields	
Have you ever felt unwell after receiving a vaccination other than the influenza vaccination?						NO)	'ES			rately. rrwise you may not	
(Name of vaccination: (Symptom:											ven the vaccine.	
Have you ever been diagnosed with a serious illness such as congenital abnormality, heart, kidney,)	ΈS				
liver, blood, central nerve disease, malignant tumor, immune deficiency or any other diseases? If yes, please specify. (
If yes, have your doctor approved your influenza vaccination?								VO				
Have you ever developed convulsion?							> \	'ES				
If yes, about() times and () years old at the time of the last episode. If yes, did it come with fever?						NO	Y	'ES				
Have you ever been diagnosed with interstitial pneumonia, bronchial asthma, or other types of							> \	'ES				
respiratory illnesses? If yes, please specify. () Have you ever had a rash, hives, or other allergic reaction to certain medicines or foods												
(eggs or chicken etc.)?							ノ '	'ES				
If yes, pleas (Symptoms:	e specify. (Cause:)							
	ny close relatives who f	elt ill following	a vaccination?		,	NO		'ES				
	y of your relatives been	n diagnosed wit	h a congenital imm	unodeficiency?		NO NO		ΈS				
•	(Females only) Are you pregnant? If yes, have your doctor approved your influenza vaccination?							not sure				
	questions or concerns			cination, please	write them h	YES nere.		10				
()		If vo	ou choose to	
			Vaccine	e recipient:							eive the vaccine,	
	have answered the above		itely.	·							ase fill your	
I understand the benefits and risks of this vaccine, including the possibility of rare but serious adverse reactions, and I give my consent to receive the vaccine signature. 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(の署名又は言	记名押印_						
Dha. I	h 夕	拉廷目			中体	ムク やきた	. B D					
メーカー名	カー名. ロット番号	接種量 	ㅎ뉴ᄴᄜ ᆂ ᆣ-	七学 原油 冲击	実施機関. 医 	叫句. 按性件	- A D					
		0. 5 mL (皮下)	実施機関: 果尿ス 	大学 保健·健康持 在 E		医師名·						

接種年月日: 20 年 月 日

Lot No.

医師名:

2025 Influenza Vaccination Questionnaire Please take your Please answer all items inside the bold fr **Sample for Staff** 36.4 Body temperature temperture on the Pencils or erasable pens are not allowed. morning of the flu Female 1973 / 4 /12 Date of birth: Hoken Hanako Name vaccination and (Age: 51 Male (Year / Month / Day) fill it in. Address Common ID -1-5 Kashiwanoha, Kashiwa-shi, Chiba 123456789 ID No. Health L Student Staff Ext. **63040** (Ext. hoken.hanako@××.u-tokyo.ac.jp - 0000 E-mail pho Guardian's agreement The Common ID is the 10 digit number printed on the bottom right hand corner of your ID Card. (if under 18) 共通IDとは(What is the Common ID?)/東京大学 保健センター Questions Doctor's use Answers Did you read the "Key Facts About Seasonal Flu Vaccine", and understand the efficacy YES NO and risks of the vaccine? If you have not read the YES NO Is this your 1st influenza vaccination of this season? explanatory text, you will Are you feeling unwell at all today? NO YES not be given the vaccine. If yes, please specify. (runny nose Please read the Are you currently going to a doctor for any sort of illness? YES NO explanatory text on the) If yes, please specify. (other side of this form. Are you receiving any treatment (medication, etc)? NO YES If yes, please specify. (Have you been ill within the past 1 month? YES NO If yes, please specify. (Has anyone around you had influenza, measles, rubella, chickenpox, mumps or other infectious YES diseases within the past 1 month? If yes, please specify. (Have you received any vaccination within the past 1 month? YES If yes, please specify. (YES Have you ever felt unwell after receiving a influenza vaccine? ЙÜ Please fill in all If yes, please specify. (NO YES appropriate fields Have you ever felt unwell after receiving a vaccination other than the influenza vaccination? accurately. If yes, please specify the name of vaccination and symptoms. Otherwise you may not Have you ever been diagnosed with a serious illness such as congenital abnormality, heart, kidney, be given the vaccine. NO YES liver, blood, central nerve disease, malignant tumor, immune deficiency or any other diseases? If yes, please specify. (If yes, have your doctor approved your influenza vaccination? YES NO YES NO Have you ever developed convulsion? If yes, about() times and () years old at the time of the last episode. NO YES If yes, did it come with fever? Have you ever been diagnosed with interstitial pneumonia, bronchial asthma, or other types of NO YES respiratory illnesses? If yes, please specify. (Have you ever had a rash, hives, or other allergic reaction to certain medicines or foods NO YES (eggs or chicken etc.)? If yes, please specify. (Cause: (Symptoms: **NO** Do you have any close relatives who felt ill due to a vaccination? YES NO YES Have you or any of your relatives been diagnosed with a congenital immunodeficiency? NO YES / not sure (Females only) Are you pregnant? If yes, have your doctor approved your influenza vaccination? YES NO If you have any questions or concerns about your health or today's vaccination, please write them here. If you choose to Vaccine recipient: receive the vaccine, I confirm that I have answered the above questions accurately. please fill your I understand the benefits and risks of this vaccine, including the possibility of rare but serious adverse reactions, and I give my consent to receive the vaccine. signature. Influenza HA vaccination [manufactured in Japan] <u>Hanako</u> Hoken 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(見合わせる)。 可能 医師の署名又は記名押印 接種量 ワクチンメーカー名. ロット番号 実施機関. 医師名. 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 0. 5 mL

月

日

医師名:

(皮下)

Lot No.

接種年月日: 20