2025 Influenza Vaccination Questionnaire

Please answer all items inside the bold frame
Pencils or erasable pens are not allowed.

Sample for Students

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,		Common ID	123456789
Student ID No.	99 - 000000	Laboratory: Health Laboratory (Ext. 63040)		
E-mail	hoken.hanako@××.u-tokyo.ac.jp		phone	090- [illegible]
Guardian's agreement (if under 18)	I, ( ), give my consent for the individual named above to receive the influenza vaccination. Signature:			

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

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

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.

Questions	Answers		Doctor's us
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, please specify. (runny nose)	NO	[illegible]	
Are you currently going to a doctor for any sort of illness? If yes, please specify. (Name of disease:)	NO	YES	
Are you receiving any treatment (medication, etc)? If yes,please specify. (Name of medications:)	NO	YES	
Have you been ill within the past 1 month? If yes, please specify. ( )	NO	YES	
Has anyone around you had influenza,measles, rubella, chickenpox, mumps or other infectious diseases within the past 1 month? If yes, please specify. ( )	NO	YES	
Have you received any vaccination within the past 1 month? If yes, please specify. ( )	NO	YES	
Have you ever felt unwell after receiving a influenza vaccine? If yes, please specify the name of vaccination and symptoms. ( )	NO	YES	
Have you ever felt unwell 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? If yes, please specify. ( ) If yes, have your doctor approved your influenza vaccination?	NO / YES	YES / NO	
Have you ever developed convulsion? If yes, about( ) times and ( ) years old at the time of the last episode. 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? If yes, please specify. ( )	NO	YES	
Have you ever had a rash, hives, or other allergic reaction to certain medicines or foods (eggs or chicken etc.)? If yes, please specify. (Cause:) (Symptoms:)	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, have your doctor approved your influenza vaccination?	NO / YES	YES / not sure / NO	
If you have any questions or concerns about your health or today's vaccination, please write them here. ( )			

Vaccine recipient:

I confirm that I have answered the above questions accurately.
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 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：

2025 Influenza Vaccination Questionnaire

Please answer all items inside the bold fr
Pencils or erasable pens are not allowed.

Sample for Staff

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		Common ID	123456789
Student	ID No. – Laboratory (Ext.)	Staff	Affiliation	Health La atory (Ext. 63040)
E-mail	hoken.hanako@××.u-tokyo.ac.jp		pho	00 - 0000
Guardian's agreement (if under 18)	I, (			

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

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

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, please specify. (runny nose)	NO	YES	
Are you currently going to a doctor for any sort of illness? If yes, please specify. ( )	NO	YES	
Are you receiving any treatment (medication, etc)? If yes, please specify. ( )	NO	YES	
Have you been ill within the past 1 month? If yes, please specify. ( )	NO	YES	
Has anyone around you had influenza, measles, rubella, chickenpox, mumps or other infectious diseases within the past 1 month? If yes, please specify. ( )	NO	YES	
Have you received any vaccination within the past 1 month? If yes, please specify. ( )	NO	YES	
Have you ever felt unwell after receiving a influenza vaccine? If yes, please specify. ( )	NO	YES	
Have you ever felt unwell after receiving a vaccination other than the influenza vaccination? If yes, please specify the name of vaccination and symptoms. ( )	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? If yes, please specify. ( ) If yes, have your doctor approved your influenza vaccination?	NO YES	YES NO	
Have you ever developed convulsion? If yes, about( ) times and ( ) years old at the time of the last episode. 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? If yes, please specify. ( )	NO	YES	
Have you ever had a rash, hives, or other allergic reaction to certain medicines or foods (eggs or chicken etc.)? If yes, please specify. (Cause:) (Symptoms:)	NO	YES	
Do you have any close relatives who felt ill due to 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, have your doctor approved your influenza vaccination?	NO YES	YES / not sure NO	
If you have any questions or concerns 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 confirm that I have answered the above questions accurately.

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 vacc

Influenza HA vaccination [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：