	20	23 Influ	enza Vaccin	ation (Questi	ionnaire	•					
Sample for Students Please answer all items inside the bold frame. Body t							36	3 ℃	Please take your temperture on the			
riease ariswei	Fem					of birth :	2004 /		morning of the flu			
Name	Hoke	en Ha	anako	Male		Month / Day)	2004	(Age: 19	vaccination and) fill it in.			
Address	₹277-8540	⁾ 5-1-5	Kashiwanol	ha, Ka	shiwa [.]	-shi, Ch	iba		Please fill in this fiel			
ID No.		aboratory 📙	alth Laborator		Affiliatio			<	completely.			
Student 90	<u>- 000000</u>		(Ext. 6304)	- Otai	Ť		(E	xt.	Otherwise you will not be able to			
E-mail	hoken.ha	anako@>	X.u-tokyo.	ac.jp		phon	e 090 - 0	000 - 000				
Guardian's agi	reement I, (), agree that the a	above-menti	oned person	may receive tl	ne influenza vaco	ination.	If your age is under 18			
(if under 1	18)				Signatu	re:			we require your			
		Questions				Δn	swers	Doctor's us	guardian's consent and signature for you to			
Did vou read t	he "Kev Facts About		cine" on the back of th	his sheet, and	d	YES	NO	Doctor's us	receive your			
understand the	Did you read the "Key Facts About Seasonal Flu Vaccine" on the back of this sheet, and understand the efficacy and risks of the vaccine?								vaccination. Without your gardian's			
	t influenza vaccinatio					YES NO	NO		signature, you can not			
	ntly going to a doctor ne of disease:	for any sort of hir	ess?)	NO		(receive the vaccine.			
Are you receiv	ring treatment (medica	ation, etc)?				NO	YES					
=	ne of medications:	aa aluimbt fan van	ra waasiya tha inflyana	a vaaaimatiam)	YES	NO	If	you have not read the			
	g unwell at all today?	as airight for you	to receive the influenz	a vaccination	1 .	NO	YES		kplanatory text, you wil			
If yes, how	(runny no)				ot be given the vaccine. ease read the			
=	=		uch as congenital abno	=	-	NO	YES		cplanatory text on the			
(Name of a		ialignant tumor, in	mune deficiency or an	ly other disea	ises:			ot	ther side of this form.			
•	your doctor agree w	th you receiving t	he flu vaccination?		ŕ	YES	NO					
•	n sick in the last mont	h?			`	NO	YES					
(indicate if Has anvone ar		a. measles. rubell	a. chickenpox. mumps	or other infed	tious	NO		Pleas	e fill in all			
•	Has anyone around you had influenza, measles, rubella, chickenpox, mumps or other infectious diseases in the last month?						YES		opriate fields			
(indicate if any: Have you received any vaccinations in the last month?						NO	YES		ately.			
наve you rece (indicate if		in the last month	<i>:</i>)	NO	150		rwise you may not ven the vaccine.			
·	felt sick because of	the influenza vaco	ination?		·	NO	YES					
(indicate if		ng a vaccination?	(Excluding the influenz	za vessinatio)	NO	YES					
(indicate if		ng a vaccination:	(Excluding the influenz	za vaccinatio)	NO	TES					
=		other reaction to	certain medicines or f	foods		NO	YES					
(eggs or chick	ken etc.)? medicine and food:)							
•	at that time:)							
-	Any history of seizure? () Age Time											
	t come with fever?	interctitial pneum	onia, bronchial asthma,	or other typ	es of	NO	YES					
respiratory illn		ci suuai piiculli	onia, bronomai asumia,	, от оснет сур		NO	YES					
			n a congenital immuno	deficiency?		NO	YES		_			
	ny close relatives who	o felt ill following a	a vaccination?			NO	YES / not sure		_			
-	your doctor agree to	vour receiving th	e flu vaccination?			YES	NO					
_			ctor about your health	or today's v	accination, p							
()		If you shoose to			
			Vaccine red	cinient:					If you choose to receive the vaccine,			
I have answered	I the questions above co	rrectly and underst	anding the merits and risl	-	accine, inclu	ding the rare but	severe adverse re		please fill your			
	eceive the influenza vac								signature.			
Intluenza HA	vaccination (quadrivale	nt vaccine) [manufa	ctured in Japan]		Signati	ire: Hak	en Ho	naka				
					Jigi latt			HUNU				
For doctor's use			医红色	入担					_			
以上の問念笙	 の診察の結果、今日	の予防接種は(<u>へ懶</u> わせる)								
<u> </u>	H2 3/1 ** (**	1 WITM [- 3 NO 96 A		。)署名又はi	记名押印						
	± 2 = 1 = 2	1+12 P							<u></u> -			
	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		0. 5 mL (皮下)	実施機関:東京大学									
Lot No.		(皮下)	接種年月日: 20	年 月	日	医師名:						

Lot No.

		intlu	enza Vaccii	nation (Zuesti	onnaire				
Sample for Staff Please answer all items inside the bold frame.) .	Body temperat		mperature	ture 36.4		Please take your temperture on the morning of the flu	
Name	Hoke	en Ha	anako	Female Male		of birth: Nonth / Day)	1973 /	4 /12 (Age:50)	vaccination and	
Address	〒 277-8540	5-1-5	Kashiwano	oha, Kas	shiwa-	-shi, Chi	ba			
ID No.	T277-8540 5-1-5 Kashiwanoha, Kashiwa-shi, Chiba Laboratory (Ext.) Staff Affiliation Health Laboratory							kt. 63040	Please fill in this field completely. Otherwise you will	
E-mail	hoken.har	nako@X	×.u-tokyo.	ac.jp		phon		000 - 0000	not be able to receive the vaccine.	
Guardian's agr	reement I, (), agree that the	e above-mentio	ned person	may receive th	e influenza vacc	ination.		
(if under 1	8)				Signatu	re:]	
Questions							wers	Doctor's use		
=	ne "Key Facts About S		cine" on the back of	this sheet, and	l	YES	NO		1	
	e efficacy and risks of the influenza vaccination					YES	NO		_	
Are you curren	itly going to a doctor f		ness?			NO				
=	e of disease: ing treatment (medicat	tion oto)?)	NO	YES			
	ing treatment (medical ne of medications:	tion, etc)?)	NO	IES	15.00		
	treating you say it wa	s alright for you	to receive the influer	za vaccination	?	YES	NO		f you have not read the explanatory text, you will not be given the vaccine. Please read the explanatory text on the	
-	g unwell at all today?	20			,	NO	YES			
=	been diagnosed with a	serious illness	-		-	NO	YES			
liver, blood, cer (Name of a	ntral nerve disease, ma	alignant tumor, ir	nmune deficiency or a	any other disea	ses?	110	120	•	er side of this form.	
•	your doctor agree wit	h you receiving	the flu vaccination?		,	YES	NO			
	sick in the last month	1?				NO	YES			
	(indicate if any: Has anyone around you had influenza, measles, rubella, chickenpox, mumps or other infectious						Please			
diseases in the		a, measies, rubeii	a, Chickenpox, mumps	s or other lineo	tious	NO	YES		fill in all riate fields	
(indicate if a)			accurat	ely.	
Have you recei	ived any vaccinations i	in the last month	n?)	NO	YES		vise you may not	
	felt sick because of the	ne influenza vac	cination?		,	NO	YES	be giver	n the vaccine.	
(indicate if a)				1	
Have you ever (indicate if a	felt sick after receivin any:	ng a vaccination?	(Excluding the influe	nza vaccinatior	1.))	NO	YES			
	r had a rash, hives, or	other reaction to	o certain medicines or	foods		NO	YES			
(eggs or chick	en etc.)? nedicine and food:				,					
(Condition a)					
Any history of		() Age Time			NO	YES			
	come with fever?	nterctitial pneum	onia bronchial acthm	a or other type	es of	NO	YES		_	
respiratory illne	_	nterstitiai pheun	ionia, bronchiai ascilii	a, or other type	25 01	NO	YES			
Have you or an	ny of your relatives be			odeficiency?		NO	YES]	
	ny close relatives who Are you pregnant?	telt ill following	a vaccination?			NO	YES / not sure		-	
	your doctor agree to	vour receiving th	ne flu vaccination?			YES	NO			
	questions that you w			th or today's va	accination, p				_	
()	(E.	vou abassa ta	
			Vaccine r	ecinient:					you choose to ceive the vaccine,	
I have answered	the questions above cor	rectly and unders		-	accine, includ	ling the rare but	severe adverse rea		ease fill your	
	eceive the influenza vacc							sig	gnature.	
Influenza HA	vaccination (quadrivalen	t vaccine) [manufa	actured in Japan]		Signatu	re: Hab	en Ha	naka		
					Jignatu	··· I IUN		HUNU	J	
or doctor's use				1 7 488					1	
いしの田参佐	の診察の結果 今日の	N 圣 叶 拉 辞 计 /	医師記 一 日本						-	
以上の问診寺	の診察の結果、今日 <i>0</i>	ソア 収 技性は (可能 • 見台	らわせる)。 医師 <i>の</i>	。)署名又は言	2夕畑印				
					/百つ人は記				-	
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		0. 5 mL	実施機関: 東京大学	学 保健・健康推	進本部					
Let No		(皮下)	 接種年月日: 20	年 日	В	医師名:				

月

年

接種年月日: 20

Lot No.

日

医師名: