

Prevaccination Screening Questionnaire for COVID-19 vaccine

*Please fill in or check the boxes inside the bold frame

Address on the resident card	Prefecture	City	
	Address		
Furigana			
Name	Tel. No.	()	
Date of birth	Year	Month	Day () years old
	<input type="checkbox"/> male <input type="checkbox"/> female		Body temperature before examination
			Degrees

注意

本予診票を用いて請求を行うことはできません。

日本語の予診票に転記の上、請求を行ってください。

Question	Response field	Field filled in by doctor
Are you receiving the COVID-19 vaccine for the first time? (If you have been vaccinated before, date of 1st time: MM/ DD, date of 2nd time: MM/ DD)	<input type="checkbox"/> yes <input type="checkbox"/> no	
Is the city, town, or village where you currently reside the same as the city, town, or village stated on the coupon?	<input type="checkbox"/> yes <input type="checkbox"/> no	
Have you read the "Instructions for the COVID-19 vaccine" and do you understand the effects and adverse side effects?	<input type="checkbox"/> yes <input type="checkbox"/> no	
Do you fall into one of the target groups that have a higher priority for this vaccine? <input type="checkbox"/> Medical personnel, etc. <input type="checkbox"/> Person 65 years or older <input type="checkbox"/> Person 60 to 64 years old <input type="checkbox"/> Worker at a senior citizen facility, etc. <input type="checkbox"/> Person with an underlying disease (name of disease:)	<input type="checkbox"/> yes <input type="checkbox"/> no	
Are you currently suffering from any kind of illness and receiving treatment or medication? Name of disease: <input type="checkbox"/> heart disease <input type="checkbox"/> kidney disease <input type="checkbox"/> liver disease <input type="checkbox"/> blood disease <input type="checkbox"/> disease that makes it difficult to stop bleeding <input type="checkbox"/> immune deficiency <input type="checkbox"/> other () Nature of treatment: <input type="checkbox"/> blood-thinning medicine () <input type="checkbox"/> other ()	<input type="checkbox"/> yes <input type="checkbox"/> no	
Has a doctor who is treating you for the disease told you that you can have the vaccine today?	<input type="checkbox"/> yes <input type="checkbox"/> no	
Have you had a fever or gotten sick in the last month? Name of disease ()	<input type="checkbox"/> yes <input type="checkbox"/> no	
Are there any parts of your body that are not feeling well today? Condition ()	<input type="checkbox"/> yes <input type="checkbox"/> no	
Have you ever had a convulsion (seizure)?	<input type="checkbox"/> yes <input type="checkbox"/> no	
Have you ever experienced severe allergic symptoms (such as anaphylaxis) from medications or foods? Medication or food that caused the problem ()	<input type="checkbox"/> yes <input type="checkbox"/> no	
Have you ever been sick after receiving a vaccine? Type of vaccine () Condition ()	<input type="checkbox"/> yes <input type="checkbox"/> no	
Is there any possibility that you are currently pregnant (for example, your period is later than expected)? Or are you breastfeeding?	<input type="checkbox"/> yes <input type="checkbox"/> no	
Have you had any vaccines within the last two weeks? Type of vaccine () Date of vaccine ()	<input type="checkbox"/> yes <input type="checkbox"/> no	
Do you have any questions about the vaccine today?	<input type="checkbox"/> yes <input type="checkbox"/> no	

Field filled in by doctor	In light of the results of the questions above and examination, today's vaccine is (<input type="checkbox"/> possible, <input type="checkbox"/> not possible). I have explained the effects of the vaccine, side effects, and the Relief System for Injury to Health with Vaccination to the patient.	Signature and seal of doctor
	<input type="checkbox"/> The person to be vaccinated is under 6 years old (fill in if applicable)	

COVID-19 Vaccination Request Form

After receiving a medical examination and explanation from a doctor and understanding the effects and side effects of the vaccine, do you wish to receive this vaccine?
(I wish to be vaccinated/ I do not wish to be vaccinated)

The purpose of this preliminary medical examination form is to ensure the safety of the vaccine.

I understand this and consent to this prevaccination Screening Questionnaire being submitted to the municipal government, the All-Japan Federation of National Health Insurance Organizations, and the National Health Insurance Organization.

Signature of vaccinated person or their guardian
Date: _____
(*If the person to be vaccinated is unable to sign the form by himself/herself, a representative must sign the form, and the representative's name and relationship to the person to be vaccinated must be indicated.) (*In the case of a person under 16 years of age, the form must be signed by the guardian; in the case of an adult ward, the form must be signed by the person himself/herself or the adult guardian.)

Field filled in by doctor	Name of vaccine and lot number	Inoculation amount	Vaccination location, name of doctor, and date of vaccination	*Please fill in the medical institution code and vaccination date so that they fit within this field.
	Seal position	ml	Vaccination location	Medical institution code
	*Paste it <u>straightly</u> along with the frame. (Note: Make sure that the expiration date has not expired.)		Name of doctor	Date of vaccination *Example: April 1, 2021 →2021/04/01