

# Prevaccination Screening Questionnaire for COVID-19 vaccine

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

## 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。

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

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		Vaccination location	Medical institution code
	*Paste it <u>straightly</u> along with the frame. (Note: Make sure that the expiration date has not expired.)	ml	Name of doctor	Date of vaccination *Example: April 1, 2021 →2021/04/01