INFLUENZA VACCINATION FORM for SENIORS (65+)

★ **Please bring BOTH this English form and the original Japanese form that was mailed to your residence (in September 2019) to your vaccination appointment.**

QUESTIONNAIRE	ANSWER		DOCTOR COMMENTS
Did you read the explanation of influenza that was included with the original vaccination form (Japanese document) that was mailed to you?	YES	NO	
Did you understand everything about the benefits and side effects of the vaccination you will be receiving today?	YES	NO	
Do you currently have any conditions? NAME OF CONDITION: ( )	YES	NO	
Are you being treated for your aforementioned condition?	YES	NO	
Have received permission from your primary care physician to be vaccinated today?	YES	NO	
Have you ever been diagnosed with immunodeficiency?	YES	NO	
Are you having any trouble with your overall health today? SPECIFIC SYMPTOMS: ( )	YES	NO	
Are you allergic to chicken meat and/or eggs?	YES	NO	
Have you ever been vaccinated for influenza before?	YES	NO	
① Did you feel ill after being vaccinated?	YES	NO	
② Have you ever felt ill following any other vaccinations?	YES	NO	
Have you ever had seizures or convulsions?	YES	NO	
Have you been vaccinated within the past month? NAME OF VACCINATION: ( )	YES	NO	
Have you ever been diagnosed with heart disease, kidney disease, liver disease, hematological (blood) disease, or any such chronic conditions? NAME OF CONDITION: ( )	YES	NO	
Have you had a fever or gotten sick in the past month? NAME OF CONDITION: ( )	YES	NO	
Do you have any questions regarding your vaccination today?	YES	NO	

INFLUENZA VACCINATION STATEMENT OF CONSENT

(Please fill out following your medical examination and after receiving doctor consent)

Following an examination by a doctor and hearing their explanation of the benefits and possible side effects, do you wish to proceed with the vaccination?	**I WISH TO PROCEED ・ I DO NOT WISH TO PROCEED** (please circle one)

I understand that the purpose of this medical form is to guarantee the safe administration of vaccinations and hereby consent to the release of this form to the municipal government.

Date: **年 Y** **月 M** **日 D**	(※for those who are physically unable to sign please designate a proxy. Your proxy must identify their relation to you)
Vaccinated Person:	**Proxy:** **Relation:**