Influenza Vaccination Form
（for CHILDREN）

（ Middle school & younger : 1st round ・ 2nd round ）

（ High School: 1st round ） ※Please circle which applies

			TEMPERATURE	℃
ADDRESS			PHONE NUMBER	
CHILD NAME		M ・ F	DATE OF BIRTH	年Y 月M 日D
PARENT / GUARDIAN NAME			AGE	（ Years Months）

QUESTIONNAIRE		ANSWERS		DOCTOR COMMENTS
Please answer the following questions regarding your child's development				
※ for those under elementary school age only weight at birth （ ） g	Were there any complications at time of birth?	Yes	No	
	Were there any postpartum complications?	Yes	No	
	Have you ever been told of complications at a check up?	Yes	No	
From birth until now, has your child ever been diagnosed and treated for any congenital, kidney, liver neurological, or immunodeficiency conditions? Name of condition: （ ）		Yes	No	
Have you received permission by your primary care physician for your vaccination today?		Yes	No	
Does your child have any problems or concerns with their overall health today? Please specify your symptoms: （ ）		Yes	No	
Within the past month, has your child come in contact with anyone who was diagnosed with influenza, measles, rubella, chicken pox, or the mumps? Name of disease: （ ）		Yes	No	
Was your child vaccinated within the past month? Type of vaccination: （ ）		Yes	No	
Has your child ever been vaccinated for influenza?		Yes	No	
Did your child have any negative reactions to the vaccination?		Yes	No	
Has your child ever had any negative reactions to any other vaccinations? Type of vaccination: （ ）		Yes	No	
Is your child allergic to chicken meat and/or eggs?		Yes	No	
Has your child ever developed a rash or become ill after ingesting certain medications or foods?		Yes	No	
Has your child ever had any convulsions or seizures （ ） years old at time of incident		Yes	No	
Did they have a fever when it happened?		Yes	No	
Has anyone in your immediate family had negative reactions to vaccinations?		Yes	No	
Has anyone in your immediate family been diagnosed with primary immunodeficiency syndrome?		Yes	No	
Do you have any questions regarding today's vaccination?		Yes	No	
（For female patients only） Is your child pregnant or is there a possibility that your child is pregnant?		Yes	No	

For Doctor Use

医師の記入欄

以上の問診及び診察の結果、今日の予防接種は （ 可能 ・ 見合わせる ）

保護者に対して、予防接種の効果・目的、接種するワクチンの有益性及び副反応並びに予防接種健康被害救済制度について説明した。

医師の署名
又は記名押印

※13歳以上の中学生で、2回目接種が必要な場合はその理由を記載

Parent / Guardian Consent

※ Influenza vaccinations administered between **October 1 – February 2020** are subject for municipal government financial aid

1. Following an examination by a doctor and understanding their explanation of the benefits, purpose, efficacy, and possible side effects as well as the national vaccination program, I （ wish ・ do not wish ） to proceed with the vaccination
2. I authorize the vaccinating clinic as the recipient of the municipal government financial aid for vaccinations

（令和）REIWA 年Y 月M 日D Parent / Guardian Name:

For Clinic Use

ワクチンメーカー名、ロット番号	接種量	実施場所・医師名・接種年月日
メーカー名 Lot No.	ml	実施場所 医師名 接種年月日 令和 年 月 日

Fujiyoshida ・ Doshi ・ Nishikatsura ・ Oshino ・ Yamanakako ・ Narusawa ・ Fujikawaguchiko

（ Please circle the name of your municipality ○ ）