Pre-vaccination Screening Questionnaire: Influenza(Flu)

Please answer the questions **in the thick frame and bring this form** to your appointment.

(write with a ballpoint pen)

Body Temperature before vaccination ℃

Student number (7 digits):	TEL: E-mail:
Name: M ・ F	Date of birth Age: *A signature by parent or guardian is required (for students under age 20)

Parent/Gurdian of a student under age 20, please fill this box
I read through and understand the information concerning the objectives, benefits, and risks of vaccination. I do give consent of this person to receive vaccination if the docter determined it clinically possible and the person agree to recieve one.
Parent/Gurdian's Name in print and Signature: Point of Contact (phone number):

Questions	Answers		Doctor
1.Have you read and understood the explanation of the vaccination you are about to receive today?	No	Yes	
2.Is this your first/second time to have a flu vaccination this season?	second time	first time	
3.Do you feel unwell today?	Yes(Pls specify how)	No	
4.Are you being treated by a doctor for a disease?(medication→16)	Yes(Disease name)	No	
5. Did you fall ill in the last one month?	Yes(Disease name)	No	
6. Does anyone in your family or around you contracted an infectious disease such as measles, rubella, chickenpox, mumps in the last one month?	Yes(Disease name)	No	
7. Did you have any vaccinations in the last one month?	Yes(Immunization name)	No	
8.Have you ever felt unwell after getting a vaccination?	Yes(Pls explain)	No	
9.Do you have any history of special illness (congenital abnormality, heart/kidney/liver/blood/ central nerves disease, immunodeficiency, malignant tumor or others) ?	Yes(Pls specify)	No	
If yes in the previous question, did you obtain an approval for today's vaccination from the physician who has been treating you ?	No	Yes	
10.Have you ever been diagnosed as having a respiratory disease such as interstitial pneumonia or bronchial asthma?	Yes(Age:)	No	
11.Have you ever had a convulsion?	Yes(Age:)	No	
12. Have you ever had any skin troubles/allergic reactions or become unwell by taking particular medication or food (chicken egg or/and chicken meat)?	Yes (name of medication/food)	No	
13.Has anyone in your family ever felt unwell after receiving vaccination?	Yes(Immunization name)	No	
14.Has anyone in your family been diagnosed as congenital immunodeficienfy?	Yes	No	
15. **[Women only]: Are you currently pregnant or planning pregnancy?**	Yes	No	
16. Please describe any further information which may be relevant (eg. Drugs currently taking etc.)			

Dr's comment: As the result of the questionnaire and the medical examination, today's vaccination is (Possible ・ Not possible)

I have explained to the patient the information about benefits, possible side effects of the vaccination and the support by law provided to adverse events . Doctor's name (signature)

I have understood the effects and possible side effects of influenza vaccine. I would like to have the vaccination today.

Date: Signature

Vaccine Lot No.	Dose	Confirmation by Physician ・ Inoculation date ・ Venue
	subcutaneous inoculation 0.5ml	Mariko Tanaka (M.D.) Date: Tokyo University of the Arts Health Care Service Center

Receipt (Please write your name)

(student) Name: 様

Amount ￥2,000.-

In Payment of Infulenza Vaccination

＊Validated with official stamp.

領収印
(Official Stamp)

Caution: Watch for your physical sign of allergic reaction especially for the first 30 minutes after the injection. If you find any, come back to the Health Service Center immediately.

＊Signs of a severe allergic reaction ('Anaphylaxis') may include sweating, swelling of the face , hives, difficulty breathing with drop of the blood pressure– usually within half an hour after the vaccination. Check details in the leaflet, 'Important Notice for People Receiving Influenza (Flu) Vaccination'