COVID-19 Vaccine: Overview of Medical History

※太枠内にご記入またはチェック☑を入れてください。

券請券氏

Please read the "COVID-19 Vaccine Information " sheet before filling out this form.

There are 9 items that you will have to fill out.

① Address: Chiba (都道府県) Kamogawa (市町区村) Yokosuka 1450

② フリガナ / Name: SMITH John

③ TEL: (090) 1234－5678

2312345612345678901

⑤

⑥

④ Birthdate: 1990 02 11 (year, month, day) 033 yrs. old (age) ☑ M · ☐ F

Body Temperature: 36.5 °C

⑦ 質問事項	回答欄		医師記入欄
Have you been vaccinated with COVID-19 Vaccine? date of 1st shot: and/2nd (year, month, day) Vaccine Name ( ) Pfizer, Moderna, etc…	☐ Yes	☐ No	
Is your address the same as the address written on the coupon above?	☐ Yes	☐ No	
Did you understand everything that was written on the explanation about the vaccine?	☐ Yes	☐ No	
Are you currently being treated for other conditions? If yes, what type of condition is it? ☐ heart ☐ kidney ☐ liver ☐ blood ☐ diseases that affect blood clotting ☐ immunodeficiency ☐ capitllary leak syndrome ☐ other ( ) If you are receiving treatment, please tell us what kind of medicines or treatments: ☐ blood thinning medicines ☐ other ( )	☐ Yes	☐ No	
Have you had a fever or gotten sick in the past month? (If you got sick, what was it?:)	☐ Yes	☐ No	
Do you feel ill today? (If yes, tell us about it:)	☐ Yes	☐ No	
Have you ever had a seizure?	☐ Yes	☐ No	
Have you ever had a severe allergic reaction to any foods or medicines? (What foods or medicines:)	☐ Yes	☐ No	
Have you ever felt ill or gotten sick after getting other vaccinations? (What vaccine?: What happened?:)	☐ Yes	☐ No	
Are you pregnant or are you currently nursing a child?	☐ Yes	☐ No	
Have you been vaccinated within the past 2 weeks? (Vaccine: When:)	☐ Yes	☐ No	
Is there anything you would like to ask about your vaccination today?	☐ Yes	☐ No	

Your answers for ⑦ has to be written in Japanese.

Please write a ✓ in either box.

Please read each statement and place a ✓ in the answer box.

COVID-19 Vaccination Approval

After reading about the vaccine and listening to the doctor, I understand the potential effects and outcomes of the vaccine.

⑧ ☐ I will get vaccinated. ☐ I will not get vaccinated.

この予診票は、接種の安全性の確保を目的としています。

このことを理解の上、本予診票が市町村、国民健康保険中央会及び国民健康保険団体連合会に提出されることに同意します。

⑨ [Today's date (yyyy/mm/dd)] 2023年 10月 23日

被接種者又は保護者自署 [Write your name or your guardian's name] John Smith

（※自署できない場合は代筆者が署名し、代筆者氏名及び被接種者との続柄を記載）
（※被接種者が16歳未満の場合は保護者自署、成年被後見人の場合は本人又は成年後見人自署）

医師記入欄

ワクチン名・ロット番号	接種量	実施場所・医師名・接種年月日 ※医療機関等コード・接種年月日は枠内に収まるよう記入してください。
シール貼付位置 ※枠に合わせてまっすぐに貼り付けてください （注）有効期限が切れていないか確認	ml	実施場所 医師名 医療機関等コード 接種年月日 ※記入例）4月1日→04月01日 2 0 2 □ 年 □□ 月 □□ 日