

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。

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 区 町 村
Yokosuka 1450

フリガナ
 ② Name **SMITH Mark** ③ TEL (**090**) **1234-5678** ⑤ 231234561234567890 ⑥

④ Birthdate **20200211** (year, month, day) **003** yrs. old (age) M · F Body Temperature **36.5** °C

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

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。

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

⑨ [Today's date (yyyy/mm/dd)] 被接種者又は [Write your name or your guardian's name]
2023年 10月 23日 保護者自署 **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成年被後見人自署)

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
	シール貼付位置	<input type="checkbox"/> <input type="checkbox"/> ml	実施場所
	※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		医師名
			接種年月日 ※記入例) 4月1日→04月01日 202 年 <input type="checkbox"/> 月 <input type="checkbox"/> 日

Write the guardian's name.