Influenza HA Vaccination Request Form / Preliminary Questionnaire

For Voluntary Vaccination

This preliminary questionnaire cannot be used for routine vaccination.
Please use a questionnaire provided by your municipal government.

Manufacturer & Distributor:
Kitasato Daiichi Sankyo Vaccine Co., Ltd.
6-111 Arai, Kitamoto-shi, Saitama, Japan

Please Read Before You Request Influenza HA Vaccination

1. Influenza and complications

Influenza is a respiratory infection with the influenza virus that spreads by air and hands when a patient coughs and sneezes. In 1 to 5 days after a person is infected, some symptoms begin to appear, including tiredness, sudden fever, sore throat, coughing, and sneezing, which normally disappear in about a week. However, in the case of an elderly person, a baby, a person with a weakened immune system, or an adult with less physical strength, close monitoring is necessary because serious complications (such as pneumonia, death, etc.) are possible.

2. Effect and side effects of influenza vaccine

The effect of the vaccine has long been debated. The vaccination is expected to shorten the symptoms even if you catch the flu. It is also expected to prevent the symptoms from becoming severe enough to require hospitalization.

The side effects of the vaccine include a fever as well as redness, swelling, and induration at the injection site. Approximately, several persons out of 100 would experience a fever; and one person out of 10 would experience redness and swelling. In rare cases, the following side effects may occur: (1) shock, anaphylaxis (hives, difficulty breathing, angioedema, etc.); (2) acute disseminated encephalomyelitis (a fever, headaches, impaired mobility, impaired consciousness, etc. after several days to 2 weeks of vaccination); (3) encephalitis, encephalopathy, myelitis, optic neuritis; (4) Guillain-Barre syndrome (numbness in arms and legs, disturbance of gait, etc.); (5) seizures (including fever convulsions); (6) liver function impairment, jaundice; (7) asthmatic attack; (8) thrombocytopenic purpura, decrease in platelets; (9) vasculitis (allergic purpura, allergic granulomatous angiitis, leukocytoclastic vasculitis, etc.); (10) interstitial pneumonia; (11) mucocutaneous ocular syndrome (Stevens-Johnson syndrome); (12) nephrotic syndrome.

3. You should not receive influenza vaccination, if any of the following is true:

1) You clearly have a high fever (typically above 37.5˚C).
2) You currently have a severe and acute disease.
3) You have experienced anaphylaxis (severe allergic reactions that typically appear within 30 minutes after a vaccination, that include difficulty breathing, severe full body hives, etc.) due to any component of this vaccine.
4) Your primary care physician has advised you not to receive the vaccination.

4. You should consult your physician before receiving influenza vaccination, if any of the following is true:

1) You have an underlying condition such as a cardiovascular disease, kidney disease, liver disease, blood disease, etc.
2) You have had a rash or other abnormalities due to a medication or food (a chicken egg or meat, etc.)
3) You have a history of seizures (convulsions).
4) You have experienced a fever, full body rash, hives and other symptoms that appear to be allergic reactions within 2 days of an influenza vaccination.
5) You have previously been diagnosed with an immune disorder or have a close family member with a congenital immunodeficiency.
6) You have a respiratory illness such as interstitial pneumonia, bronchial asthma, etc.
7) You are pregnant.
8) You were born prematurely and your physical growth is slow (if you are a child).
9) Your physical growth is slow, and you are receiving care from your physician and public health nurse (if you are a child).

5. Please take the following precautions after influenza vaccination:

1) Some allergic reactions (difficulty breathing, hives, coughing, etc.) may occur during the first 30 minutes after the vaccination. Be prepared to contact a physician immediately.
2) Many of the side effects (a fever, headache, seizures, etc.) are known to appear within 24 hours. Monitor your physical condition closely for a full day after the vaccination. If you happen to experience a high fever, seizures, or any other abnormalities, consult a physician immediately.
3) After the vaccination, you may experience redness, swelling, or pain at the site of vaccination, which normally subside within 4 to 5 days. If you notice any change in your physical condition, consult a physician immediately.

4) You may take a bath after the vaccination, but do not rub the injection site.
5) Maintain your daily routine on the day of vaccination. However, you should keep the injection site clean after the vaccination, and avoid strenuous physical activities and heavy consumption of alcohol.

Please fill out the "Influenza HA Vaccination Preliminary Questionnaire" (on the back page), and receive a medical examination by a physician. Tell the physician if there is anything unusual about your health.

If you suffer from adverse health effects caused by this vaccine, you may be eligible to receive financial assistance for healthcare expenses, etc., in accordance with the "Adverse Drug Reaction Relief System". Please visit the website, etc., of the Pharmaceuticals and Medical Devices Agency for details.

Appointment for vaccination	Name of facility
MM/DD: ( ) Please arrive by: HH:MM: :	

Compiled by: Dr. Tetsuo Nakayama, Director, Kitasato Institute for Life Sciences, Kitasato University

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Body temperature before examination 診察前の体温	℃

Address 住所		TEL	
Name of vaccine recipient 受ける人の氏名		Sex 性別	Male 男　　Female 女
(Name of guardian) (保護者の氏名)		Date of birth 生年月日	year 年　month 月　day 日 (　years old 歳　(months) ヵ月)

Questions 質問事項	Answers 回答欄		Physician's comments 医師記入欄
Have you read the explanation about the vaccination you are about to receive today and understood its effect and potential side effects? 今日受けるインフルエンザの予防接種についての説明文を読み、効果や副反応などについて理解しましたか	No いいえ	Yes は　い	
Are you currently suffering from a disease, or feeling sick today? 現在、何か病気にかかっていますか、また今日具合の悪いところがありますか Name of disease, or where you feel sick: (　　) 病名、具合の悪い箇所	Yes は　い	No いいえ	
Have you had a fever or a disease within the last month? 最近1ヵ月以内に熱が出たり、病気にかかったりしましたか	Yes は　い	No いいえ	
Are you receiving any treatment (medication, etc.)? 治療(投薬など)を受けていますか	Yes は　い	No いいえ	
Does the physician who is treating you approve that you receive the vaccine today? その病気の主治医には、今日の予防接種を受けてもよいと言われましたか	Yes は　い	No いいえ	
Have you ever been diagnosed with a significant disease (congenital disorder, disease of the heart, kidney, or liver, neurological disease, immunodeficiency, blood disease, etc.)? 特別な病気(先天性異常、心臓・腎臓・肝臓・脳神経の病気、免疫不全症、血液疾患、その他)にかかったことがありますか Name of disease: (　　) 病名	Yes は　い	No いいえ	
Have you ever developed a rash or hives or became sick due to a medication or food (particularly, a chicken egg or meat, chicken-derived ingredients)? 薬や食品(特に鶏卵、鶏肉、その他の鶏由来のもの)で皮膚に発疹やじんましんが出たり、体の具合が悪くなったことがありますか Name of medication or food: (　　) 薬名・食品名	Yes は　い	No いいえ	
Have you received an influenza vaccine before? インフルエンザの予防接種を受けたことがありますか ① When was the last time?　(MM/YY:　　) 前回受けたのは ② Have you ever felt sick after the vaccination? その際に具合が悪くなったことはありますか ③ Have you ever felt sick after receiving a non-influenza vaccination? インフルエンザ以外の予防接種の際に具合が悪くなったことがありますか Name of vaccination: (　　) 予防接種名	Yes は　い Yes は　い Yes は　い	No いいえ No いいえ No いいえ	
Have you received any non-influenza vaccination within the last 4 weeks? 4週間以内にインフルエンザ以外の予防接種を受けましたか Name of vaccination: (　　) 予防接種名	Yes は　い	No いいえ	
Have you ever had a seizure (convulsions)? けいれん(ひきつけ)を起こしたことがありますか	Yes は　い	No いいえ	
Have you ever been diagnosed with interstitial pneumonia, bronchial asthma, or other types of respiratory diseases? 今までに間質性肺炎、気管支喘息などの呼吸器系疾患と診断されたことがありますか	Yes は　い	No いいえ	
Do you have a close family member with congenital immunodeficiency? 近親者に先天性免疫不全症の方がいますか	Yes は　い	No いいえ	
Have any of your close family members become sick after a vaccination? 近親者の中に予防接種を受けて、具合が悪くなった方はいますか	Yes は　い	No いいえ	

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Questions 質問事項	Answers 回答欄		Physician's comments 医師記入欄
Have any of your family members or friends contracted measles, rubella, chicken pox, or mumps within the last month? 1ヵ月以内に家族や友達に麻疹、風疹、水痘、おたふくかぜなどの病気の方がいましたか Name of disease: (　　) 病名	Yes は　い	No いいえ	
(If you are a woman) Are you currently pregnant? (ご婦人の方に)現在妊娠していますか	Yes は　い	No いいえ	
(If the recipient is a child) Please answer the following questions about the developmental history of the child: (接種される方がお子さんの場合に)あなたのお子さんの発育歴についておたずねします			
Birth weight: (　　) g 出生体重	Were there any abnormalities during delivery? 分娩時に異常がありましたか	Yes は　い	No いいえ
	Were there any abnormalities after birth? 出生後に異常がありましたか	Yes は　い	No いいえ
Were there any abnormalities found at infant checkups? 乳児検診で異常があると言われたことがありますか		Yes は　い	No いいえ
Do you have any questions about the vaccination you are about to receive today? 今日の予防接種について質問がありますか		Yes は　い	No いいえ

To be filled out by the physician
医師記入欄

On the basis of the above inquiry and examination, I conclude that the recipient (can receive / should not receive) the vaccination today.
以上の問診及び診察の結果、今日の予防接種は（　実施できる　・　見合わせた方がよい　）と判断します

I have explained to the recipient (or guardian) about the effect and potential side effects of the vaccination and the relief services in accordance with the Pharmaceuticals and Medical Devices Agency Act.
本人(もしくは保護者)に対して予防接種の効果･副反応及び医薬品医療機器総合機構法に基づく救済について説明しました

Physician' s signature or name / seal: _____
医師署名又は記名捺印

To be filled out by the recipient (or guardian)
本人記入〔もしくは保護者〕

Having received an examination and explanation by a physician, and understood the effect, purpose, and potential side effects of the vaccination, I (agree / do not agree) to receive the vaccination. (Please circle one.)
医師の診断・説明を受け予防接種の効果や目的、副反応の可能性などについて理解した上で接種することに（　同意します　・　同意しません　）どちらかを○で囲んでください

Signature: _____ (Representative' s relationship: _____)
署名　(代筆者の場合：続柄)

(If the recipient is unable to sign, have a representative do so and indicate the relationship to the recipient.)
(なお、被接種者が自署できない場合は代筆者が署名し、被接種者との続柄を記載してください。)

Name of vaccine used 使用ワクチン名	Dosage and Administration 用法・用量	Facility, Physician's name, and Time of vaccination 接種場所・医師名・接種日時
Name: Influenza HA Vaccine 名　　称：インフルエンザHAワクチン Manufacturer: Kitasato Daiichi Sankyo Vaccine Co., Ltd. メーカー名：北里第一三共ワクチン株式会社 Lot Number: 製造番号	Subcutaneous vaccination 皮下接種 mL th time	Name of facility: 医療機関名 Physician's name: 医　師　名 Time of vaccination: 接種日時 HH:MM:　　:　　MM/DD/YY:　　/　　/

The personal information you provided is used only for the purpose of preliminary examination of the vaccination.
記載いただきました個人情報はワクチン接種に関する予診にのみ使用します。