Yellow Fever Vaccination Inquiry

接種実施日時 13:30 ・ 14:30　　接種時間 :

【For Female】

1	Are you pregnant or possibly pregnant?	No ☐	Yes ☐	⇒ Please notify staff
2	Are you breast feeding?	No ☐	Yes ☐	

Person to be vaccinated

Name　M☐ F☐	Date of Birth　Y　M　D Age　(　Y　M　)
【Under 20 years old】Name of Parent or Guardian	Nationality　Japan ☐ Other(　)
Addresss　〒	Phone Number Home・Cell　–　– Emergency Contact　–　–
Destination and Purpose　Sightseeing☐ Work☐ Olympic☐ Other☐	Yellow Fever Vaccination First time☐　(　)time☐
Departure Date and Length　M　D　・　days	

接種当日確認事項

1	Current body temprerature		( ) ℃	
2	How are you feeling today?	Good ☐	Bad ☐	Details:
3	Have you ever had any problems related to medication, I.V., or vaccine?	No ☐	Yes ☐	Name・Symtom:
4	Have you ever had a test for allergy?	No ☐	Yes ☐	Test Result:
5	Are you allergic to egg, chicken meat, gelatine, latex, or other?	No ☐	Yes ☐	Name・Symptom:
6	Have you ever had athma or atopic dermatitis?	No ☐	Yes ☐	Symptom・Date:
7	Have you ever been hospitalized, or had surgery or radiation therapy?	No ☐	Yes ☐	Reason・Date:
8	Are you receiving any medical treatment, or taking medication? ※Kidney disease・Diabetes・Heart disease・Athma・Blood disease・Immune disease・Hormonal disease・cancer, etc	No ☐	Yes ☐	Please fill out below.
	Reason・Medication:			
9	Did you have blood transfusion, γ globulin, oral steroid, chemotherapy or radiation therapy in the last 3 months?	No ☐	Yes ☐	Name・Date:
10	Did you have any infectious disease in the last 1 month? ※Measles, rubella, chikenpox or mumps etc.	No ☐	Yes ☐	Name・Date:
11	Did you have any vaccination in the last 4 weeks, or plan to have one?	No ☐	Yes ☐	Please fill out below.
	Vaccine ・ Date: i.e.) Hepatitis A Feb. 26			
12	【For Child】 Did your child have any problem at the delivery?	No ☐	Yes ☐	Details:
13	【For Child】 Have you had any seizure in the last 1 year?	No ☐	Yes ☐	Number of times・Dates:

DO NOT WRITE BELOW THIS LINE

医師記入欄

診察所見	
	接種の可否： 可☐ ・ 否☐
予防接種に関する説明 ☐	担当医署名
接種後の注意事項の説明 ☐	

本人（保護者）記入欄

予防接種に関する説明、問診及び診察の結果、接種後の注意事項の説明を受け理解しましたので、本日の予防接種を受けることに同意します。
I fully understood the information given about yellow fever vaccination, results of medical examination and cautions after the vaccination. I request that the vaccination be given to me or my child.

本人（または保護者）署名：
Signature (if minor, signature of a parent or guardian):

ワクチン名	用法・用量	回数	接種部位
名称：YELLOW FEVER	皮下注射	初回	左腕
メーカー名：Sanofi, Inc	0.5 ml	（ ）回目	・
Lot No.：		追加	右腕

Information About Vaccination for Minor

Children under the age of 16 must be accompanied by a guardian.
Children under the age of 18 must be accompanied by a guardian, or have the consent of parent or guardian.

Parent / Guardian Consent

I have read the information about yellow fever vaccination, and understood the purpose, benefits and risks of the vaccination. I request that the vaccination be given to my child.

Year Month Day

Parent/Guardian Signature _____

Emergency Contact _____

※The vaccine cannot be given without signature of parent or guardian.
※Emergency contact should be reacheable before and after the vaccination.
Please provide a reacheable phone number such as home or cell phone.