

Instructions for the date of vaccination

Please be punctual for the meeting time on the date of vaccination.

It takes about 1 hour from reception to the end.

1 Meeting time

- ▣ Arrive at Shizuoka Welfare Hospital by the appointed meeting time
- ▣ Vaccination room opens 15 minutes before the meeting time

2 What to bring

- ▣ Revenue [fiscal] stamps for the price ※ **separate set** for each vaccinee
- ▣ Application for vaccination (page 3 of this file)
- ▣ Questionnaire for Yellow Fever Vaccination (page 5 and 6)
 - ※ For application and questionnaire, print and fill out the documents.
(Application: print single sided, Questionnaire: print double sided)
- ▣ Passport ※ copy or picture of the page with your name is also acceptable
- ▣ Maternal and Child Health Handbook (母子手帳、ぼし てちょう) or other vaccination records
 - ※ Only if you want the vaccination history to be recorded on documents except yellow card (International Certificate of Vaccination or Prophylaxis, ICVP)
- ▣ Guardian's Agreement
 - (when the vaccinee aged of 16 or older and younger than 18 comes alone)
 - ※ For detail, see “Guardian’s Agreement when a vaccinee aged of 16 or older and younger than 18 comes alone” PDF

3 Required time

- ▣ It takes about 1 hour from reception at vaccination room of the hospital to the end.
- ▣ You are going to wait for 30 minutes after vaccination to see if any health problems happen, and then we are going to issue yellow card (ICVP).

4 After returning home

- ▣ No specific restriction for daily activities after vaccination
- ▣ You can take a bath/shower, do exercise and drink alcohol. Refrain from hard exercise and too much alcohol.

Access to Shizuoka Welfare Hospital

Vaccination is provided at the travel clinic (in pediatric department) of **Shizuoka Welfare Hospital** (静岡厚生病院、しずおか こうせい びょういん) in Aoi Ward, Shizuoka City, Shizuoka Prefecture. NOT Shizuoka Airport in Makinohara City.

Travel clinic is on the second floor of the hospital.

From Shizuoka Station, about 10-minute bus ride and 2-minute walk.

The bus departs from **bus stop 8** at Shizuoka Station (**Inomiya Line** [120] for Sakuracho via Shizuoka Welfare Hospital, or **Seibu Loop Line** [6A] Circular Nakacho route A route) and arrives at Shizuoka Welfare Hospital (Inomiya Line) or Anzai Nichome (Seibu Loop Line).

See Shizuoka Welfare Hospital website for the detailed access (only in Japanese).

Shizuoka Welfare Hospital website (Access)

<https://ja-shizuokakosei.jp/access/index.php>

予防接種に関する申請書 APPLICATION FOR VACCINATION



申請者住所 _____
Address of applicant

申請者氏名 _____
Name of applicant

申請年月日
Date of application

署名 _____
Signature

手数料金 _____ 円
Amount of fee

名古屋検疫所中部空港検疫所支所長 殿
To the Chief of Chubu Airport Branch Office of Nagoya Quarantine Station

予防接種の施行を下記の通り申請します。
 予防接種の施行に関する証明書の交付を申請します。
 I apply for the execution of vaccination as specified below.
 I apply for the issuance of the certificate with regard to vaccination.

被 接 種 者 Persons to be vaccinated

氏 名 Name	性別 Sex	生年月日 Date of birth	予防接種の種類 Kind of vaccination	行先地 Destination	備 考 Remarks
(ふりがな) _____					
(ふりがな) _____					
(ふりがな) _____					
(ふりがな) _____					
(ふりがな) _____					

- 記載上の注意
1. 楷書で記入すること。
 2. 不要の文字はまっ消すること。
- Notes:
1. Fill in block letters.
 2. Strike out the unnecessary indications.

※If a person who wants vaccination is younger than 18, this application is required to be filled out by their guardians.

申請書
APPLICATION FOR VACCINATION

①Home address in Japan

ABC Heights 101,1-1,

申請者住所 Meieki,Nakamura-ku,Nagoya-shi,Aichi
Address of applicant

収入印紙
Revenue
Stamp

②Date yyyy/mm/dd

2025/12/1

申請年月日
Date

申請者氏名 JAMES SMITH
Name of applicant

③Full name and signature of applicant
(If the person who gets vaccinated is younger than 18, name and signature of their guardian)

JAMES SMITH

35,360 円

of fee

⑤Comma

④Total amount

- 1 Person : 17,680 Yen
- 2 People : 35,360 Yen
- 3 People : 53,040 Yen
- 4 People : 70,720 Yen
- 5 People : 88,400 Yen

名古屋検疫所中部空港検疫所支所

To the Chief of Chubu Airport

予防接種の施行を下記の通り申請し
予防接種の施行に関する証明書の発行を
I apply for the execution of vaccination
I apply for the issuance of the certificate

被接種者

Persons to be vaccinated

⑥Destination (Countries)

氏名 Name	性別 Sex	生年月日 Date of birth	予防接種の種類 Kind of vaccination	行先地 Destination	備考 Remarks
(ふりがな) JAMES SMITH	M	1950/1/1	Yellow fever	Brazil	
(ふりがな) MARY SMITH	F	2000/12/31	Yellow fever	Brazil	Blank
(ふりがな)					
(ふりがな)					
(ふりがな)					

⑦
•Name (Persons to be vaccinated)
•Sex
•D.O.B (yyyy/mm/dd)

⑧Yellow fever

- 記載上の注意
1. 楷書で記入すること。
 2. 不要の文字はまっ消すること。

- Notes:
1. Fill in block letters.
 2. Strike out the unnecessary indications.

接種時間	観察終了時間
:	:

Questionnaire for Yellow Fever Vaccination

Your number

Fill out this form correctly.
Check boxes when indicated.

Date (Year) (Month) (Day)

Name	as written on passport		Phone Number	
	(<input type="checkbox"/> Male <input type="checkbox"/> Female)		Emergency Contact Number	※In case of your medical emergency <input type="checkbox"/> Home <input type="checkbox"/> Parent's home <input type="checkbox"/> Other :
Guardian's Name	(Only for minors)	Relationship of guardian	Nationality	
Date of birth	Year / Month / Day (Age: years months)		Occupation	
Address	〒			

Today's yellow fever vaccination is for me...		<input type="checkbox"/> the first time <input type="checkbox"/> the () time (the last was in year of)		
Departure date of travel	Year / Month / Day	Destination	transit	
Duration of travel				
Purpose of travel	<input type="checkbox"/> Sightseeing <input type="checkbox"/> Business <input type="checkbox"/> Visiting Friends or Relatives <input type="checkbox"/> Study <input type="checkbox"/> Other ()			
Body Temperature before vaccination	°C	Today's condition	<input type="checkbox"/> Good <input type="checkbox"/> Not Good (in detail)	

Did you have any of the following **vaccinations within 1 month** ? Fill in **the last date** of each of vaccination, too.

I did not have any vaccination within 1 month

<input type="checkbox"/> Measles-Rubella	Month / Day	<input type="checkbox"/> Hepatitis A	Month / Day	<input type="checkbox"/> Diphtheria-Pertussis-Tetanus	Month / Day	<input type="checkbox"/> Japanese encephalitis	Month / Day
<input type="checkbox"/> Mumps	Month / Day	<input type="checkbox"/> Hepatitis B	Month / Day	<input type="checkbox"/> Diphtheria-Pertussis-Tetanus-Polio	Month / Day	<input type="checkbox"/> Rabies	Month / Day
<input type="checkbox"/> Chickenpox	Month / Day	<input type="checkbox"/> Tetanus	Month / Day	<input type="checkbox"/> Pneumococcus	Month / Day	<input type="checkbox"/> Influenza	Month / Day
<input type="checkbox"/> COVID-19	Month / Day	Month / Day	Month / Day	<input type="checkbox"/> Others ()			

Do you have any **disease under current treatment** ? Yes ※Check the following box No

Hypertension Hyperlipidemia Diabetes mellitus (the last HbA1c:) Hyperuricemia/Gout
 Atopic dermatitis Others ()

Do you take any **medicine** ? Yes ※Fill in the following box with all medicines No

Names of medicine :

If you have diseases, did your doctor give you the approval for today's vaccination ? Yes No

Fill out the other side, too.

Have you ever had any disease that needed hospitalization or surgery ?	<input type="checkbox"/> Yes	in detail	<input type="checkbox"/> No
Have you ever had seizure or convulsion ?	<input type="checkbox"/> Yes	in detail	<input type="checkbox"/> No
Have you received blood transfusion, gamma-globulin or other medicine made from human blood within 3 months ?	<input type="checkbox"/> Yes	in detail	<input type="checkbox"/> No
Do you have any allergy against medicine or vaccine ?	<input type="checkbox"/> Yes	in detail	<input type="checkbox"/> No
Do you have allergy against hen egg, chicken, pork, gelatine or other food ?	<input type="checkbox"/> Yes	in detail	<input type="checkbox"/> No
Do you eat hen egg in your daily life ?	<input type="checkbox"/> No	reason	<input type="checkbox"/> Yes
About Measles, Rubella, Mumps, Chickenpox and Influenza, COVID-19			
↳ Did you have any of the above illness within 4 weeks ?	<input type="checkbox"/> Yes	in detail	<input type="checkbox"/> No
↳ Did anyone around you have any of the above illness within 4 weeks ?	<input type="checkbox"/> Yes	in detail	<input type="checkbox"/> No
Have you ever experienced redness of skin caused by rubbing alcohol ?	<input type="checkbox"/> Yes	in detail	<input type="checkbox"/> No
(Woman Only)	Are you currently pregnant or possibly pregnant ?	<input type="checkbox"/> Yes	in detail
	Are you currently breast-feeding ?	<input type="checkbox"/> Yes	in detail

Fill in below if the vaccinee is a minor

Birth weight / Gestational age at birth	Birth weight	g	Gestational age at birth	weeks	days
Was there any abnormality at birth ?	<input type="checkbox"/> Yes	in detail			<input type="checkbox"/> No
Is any of your other children diagnosed as congenital immune deficiency ?	<input type="checkbox"/> Yes	in detail			<input type="checkbox"/> No

Do not fill in the following

診察所見 視診・咽頭所見・心音・呼吸音・触診・その他身体的所見 ※特記すべき事項があれば、以下に記載。	使用ワクチン	
	名称	黄熱ワクチン1人用
	メーカー	サノフィ株式会社
	ロット番号	
	用法・用量	皮下注射 0.5ml
接種部位	右 左 ()	
以上問診及び診察の結果、本日の予防接種の可否 <input type="checkbox"/> 可 <input type="checkbox"/> 不可		
接種日・接種時間 _____ 年 _____ 月 _____ 日 : _____ 担当医師の署名 _____		
I fully understand the instruction given by the doctor in charge of vaccination. I agree to get yellow fever vaccination. <p style="text-align: center;">Signature (For minors, signature of the guardian) _____</p>		

職員使用欄

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