

接種実施日時

13:30 ・ 14:30

接種時間

:

## Yellow Fever Vaccination Inquiry

Confirmation items	In case of emergency, I consent to the release of the information I have given to the hospital: Signature of a parent or guardian :		
For Female	1 Are you pregnant or possibly pregnant? 2 Are you breast feeding?	No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/>	⇒ Please notify staff

Person to be vaccinated			
Name	M <input type="checkbox"/>	Date of Birth	Y    M    D
	F <input type="checkbox"/>	Age	(    Y    M    )
【Under 20 years old】Name of Parent or Guardian		Nationality	Japan <input type="checkbox"/> Other (    )
Address 〒		Phone Number	
		Home・Cell	—    —
		Emergency Contact	—    —
Destination and Purpose		Yellow Fever Vaccination	
Sightseeing <input type="checkbox"/> Work <input type="checkbox"/> Olympic <input type="checkbox"/> Other <input type="checkbox"/>		First time <input type="checkbox"/> (    ) time <input type="checkbox"/>	
Departure Date and Length		M    D    ·    days	

接種当日確認事項			
1	Current body temperature	(    ) °C	
2	How are you feeling today?	Good <input type="checkbox"/> Bad <input type="checkbox"/>	Details:
3	Have you ever had any problems related to medication, I.V., or vaccine?	No <input type="checkbox"/> Yes <input type="checkbox"/>	Name・Symptom:
4	Have you ever had a test for allergy?	No <input type="checkbox"/> Yes <input type="checkbox"/>	Test Result:
5	Are you allergic to egg, chicken meat, gelatine, latex, or other?	No <input type="checkbox"/> Yes <input type="checkbox"/>	Name・Symptom:
6	Have you ever had athma or atopic dermatitis?	No <input type="checkbox"/> Yes <input type="checkbox"/>	Symptom・Date:
7	Have you ever been hospitalized, or had surgery or radiation therapy?	No <input type="checkbox"/> Yes <input type="checkbox"/>	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 <input type="checkbox"/> Yes <input type="checkbox"/>	<u>Please fill out below.</u>
Reason・Medication:			
9	Did you have blood transfusion, γ globulin, oral steroid, chemotherapy or radiation therapy in the last 3 months?	No <input type="checkbox"/> Yes <input type="checkbox"/>	Name・Date:
10	Did you have any infectious disease in the last 1 month? ※Measles, rubella, chickenpox or mumps etc.	No <input type="checkbox"/> Yes <input type="checkbox"/>	Name・Date:
11	Did you have any vaccination in the last 4 weeks, or plan to have one?	No <input type="checkbox"/> Yes <input type="checkbox"/>	<u>Please fill out below.</u>
Vaccine・Date: i.e.) Hepatitis A Feb. 26			
12	【For Child】	Did your child have any problem at the delivery?	No <input type="checkbox"/> Yes <input type="checkbox"/> Details:
13		Have you had any seizure in the last 1 year?	No <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> ・ 否 <input type="checkbox"/>
予防接種に関する説明 <input type="checkbox"/>	担当医署名	
接種後の注意事項の説明 <input type="checkbox"/>		

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  0.5 ml	初回	左腕
メーカー名：Sanofi, Inc		( ) 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 reachable before and after the vaccination.

Please provide a reachable phone number such as home or cell phone.