Pre-Vaccination Questionaire for Influenza

For voluntary vaccination

*Vaccine recipient: Please fill out parts of form within bold borders.

Temperature	℃

CompanyName (E.g. IBM/ISCJ)		Day-time contact number(external phone)		
Name		M / F	Date of birth	Y /M /D (Age:)
Health insurance certificate number/code	Code Number	Employee number		

e.g. 456-000000 (For IBM Japan employees, code is: 456, 'Number' is employee number)

Questions	Responses		To be filled in by Doctor
1. Have you read the guide explaining the vaccination you will receive today?	No	Yes	
2. Is this the first flu vaccination you have received this flu season?	No（ time(s)）	Yes	
3. Are you feeling unwell today?	Yes (Please write details）	No	
4. Are you sick and receiving medical attention at present?	Yes (Name of Medical Condition) Are you taking medication? (Yes/No)	No	
5. Have you been ill within the last month?	Yes (Name of Medical Condition)	No	
6. Are you receiving medical treatment for problems of the cardiovascular system, kidneys, lungs, or for blood diseases, immune deficiency diseases, or other illnesses?	Yes (Name of Medical Condition)	No	
7. Has anyone in your family or relatives been diagnosed with a congenital immunodeficiency?	Yes	No	
8. Has anyone in your family or relatives felt ill after receiving a vaccination?	Yes	No	
9. Have your ever experienced convulsions?	Yes Number of times At what age? years months	No	
10. Have you ever had blisters, nettle rash or reaction after receiving medicine or eating a particular food (such as eggs, chicken, etc.?)	Yes (Name of medicine/food)	No	
11. Have you ever been diagnosed with respiratory diseases such as interstitial pneumonia or bronchial asthma and are you currently being treated for it?	Yes Year approx. month （Currently being treated/Not being treated）	No	
12. Have you ever felt ill after receiving a vaccination?	Yes (Name of vaccination/condition)	No	
13. Within the past month, have you been in contact with someone who had measles, rubella, chicken pox, or mumps?	Yes (Name of Medical Condition)	No	
14. Have you received any vaccination within the last month?	Yes (Name of vaccination:)	No	
15. (For women only) Are you pregnant?	Yes	No	
16. If you have anything to inform the doctor about concerning your health, please write down details.			

To be filled in by Doctor: From my observation, using the question and diagnosis, I have concluded that the vaccination is (possible/to be given at a later date)
I hereby declare that I have explained the benefits and possible side-effects of the vaccination to the recipient based on the Act on Pharmaceuticals and Medical Devices Agency.

Doctor's signature

After receiving an examination and an explanation of the benefits and risks of the vaccination by the attending physician, are you willing to receive the vaccination? **(Yes / No)**	**Signature**

The personal information above will be used only for the influenza vaccination preexamination.

＜Consent for processing of personal data＞

I, undersigned having fully understood the purpose of collecting personal data as descried overleat, here by

☐consent to the processing of my personal data

Signature (in full name)	

Vaccine given		Dosage	Vaccination site/Doctor/Date
Influenza HA vaccine	Lot.No.	Hypodermic innoculation	Vaccination site: Doctor: Date: (year) (month) (date)
Chart No.		mL	Time:

Information regarding the influenza vaccine

Before receiving vaccination against the influenza virus, your doctor needs to know about your general health condition. It is for this reason that you are requested to enter the required information on the questionnaire to the best of your ability.

[Efficacy and side effects of the influenza vaccine]

Vaccination against the influenza virus can prevent influenza infection, complications, or death that may result from infection. Please note that known side effects to the influenza vaccine are mild in general. Redness, swelling, hardness of the skin, feeling hot, numbness, pain or eruptions with vesicles may be experienced around the injection site. These side effects will usually subside within two to three days, however. In addition, there is report of a case that led to cellulitis. Fever, chills, headaches, fatigue, transient loss of consciousness, dizziness, enlargement of lymph nodes, vomiting/nausea, diarrhea, arthritic pain, muscle pain, muscle weakness, cough or palpitations may also be experienced, but these will also be resolved within two or three days after the vaccination. Hypersensitivity may include symptoms such as rashes, urticaria, eczema, angioedema, erythema, and itchiness. Other possible side effects include paralysis such as facial nerve palsy, peripheral neuropathy, syncope due to vasovagal reflex, numbness, tremor, or uveitis.
Individuals who have an intense allergic reaction to eggs may experience stronger side effects. These individuals are instructed to inform the doctor of their allergy to eggs. The following side effects have been reported, but occur only very rarely: (1) Shock/anaphylactic symptoms (urticaria, dyspnea, angioedema etc.), (2) Acute disseminated encephalomyelitis (fever, headache, convulsions, dyskinesia, transient loss of consciousness occurring within several days to 2 weeks after inoculation), (3) Encephalitis,encephalopathy, myelitis, optic neuritis, (4) Guillain-Barre syndrome (numbness of both hands and/or feet, impaired walking, etc.), (5) Convulsions (including febrile convulsions), (6) Dysfunction of the liver, jaundice, (7) Outbreak of asthma, (8) Thrombocytopenic purpura,thrombocytopenia, (9)Vasculitis,(IgA-associated vascnlitis(Henoch-Schonlein Purpnra),allergic granulomatous angiitis(churg strauss syndrome)) (10) Interstitial pneumonia, (11) Stevens-Johnson syndrome, (12) Nephrotic syndrome, If any of the above symptoms occur, or are suspected, please consult a physician immediately. Where such an injury to health has occurred (symptoms that require hospitalization, for example), the individual concerned or a member of their family shall be able to commence proceedings for claiming medical benefits under the PMDA Law.

[Individuals who cannot receive the vaccination]

1. Individuals who are running a fever (generally of over 37.5 degrees Celsius)
2. Individuals who obviously have a serious acute illness.
3. Individuals who suffered from an anaphylactic reaction after a previous influenza vaccination.

* An anaphylactic reaction is regarded as an allergic reaction to a vaccine within 30 minutes of receiving a vaccine injection.

4. Individuals who are determined by the health practitioner as being unsuitable to receive the vaccination.

[Individuals who need to consult with physician before receiving vaccination]

1. Individuals with heart disease, kidney disease, liver disease, or blood disease.
2. Individuals with a cold
3. Individuals who showed signs of fever or rash within two days of receiving an influenza vaccine in the past.
4. Individuals who have developed a rash, or have felt unwell after meals (especially from eggs and chicken).
5. Individuals who have experienced seizures.
6. Individuals who have been diagnosed with an irregular immune system, or have a family member who have been diagnosed.
7. Individuals who may be pregnant.
8. Individuals who suffer from bronchial asthma, interstitial pneumonia, or other respiratory diseases.

Processing of your personal data for the purpose of influenza vaccination

Any personal data collected will be managed according to the regulations for the protection of personal information of our company and care will be taken to eusure the protection of your data.
We will use the information soley for the purpose of providing the influenza vaccination.

1. Purpose of collecting personal data
We will use your data solely for the pwrpose of conducting the preliminary medical interview prior to providing the influenza vaccination.

2. Where consent cannot be obtained for processing of your personal data
We may not be able to provide you with the influenza vaccination.

3. Manager for Privacy and Data Protection
1-1-7 Nishi-Waseda, Shinjyuku-ku, Tokyo 〒169-0051
Public Health Research Foundation Teruichi Shimomitu, Vice chairman

4. Contact
If you have any queries about protection of personal information, please contact:
Public Health Research Foundation
TEL 03-5287-5070 E-mail p-info@phrf.jp

＜Consent for processing of personal data＞