# For recipients of Influenza vaccine

**インフルエンザワクチンの接種について**

**Before you receive vaccination against Influenza, the doctor needs to know about your health condition in detail. Please enter precise information in the questionnaire to the best of your knowledge.**

## [Efficacy and side reactions to the vaccine]

Vaccination against influenza can prevent influenza infection or lessen symptoms in severity. Vaccination is expected to prevent complications and death that may result from influenza inflection.

On the other hand, known side reactions to influenza vaccine are mild in general. Redness, swelling, induration, feeling hot, numbness and pain may occur at the injection site but will usually resolve in 2-3 days. Fever, chill, headache, malaise, consciousness disturbance transient, dizziness, lymphadenosis, vomiting/nausea, diarrhea, arthralgia and muscle pain may also rarely be caused as a result of inoculation of influenza vaccine. Hypersensitivity symptoms (e.g., rash, urticaria, eczema, erythema, and pruritus) may also rarely be caused. Persons who show intense allergy to eggs may experience stronger side reactions. So, such a person is requested to tell it to the doctor without fail. It has been reported that following side reaction may occur very rarely.

(1)Shock/anaphylactic symptoms(urticaria and dyspnea etc), (2)Acute disseminated encephalomyelitis(fever, headache, convulsions, dyskinesia, transient loss of consciousness occur within several days to 2 weeks after inoculatio

In the case of such health function disorder, the pertinent person or his/her family member is to go through the proceedings for salvage as specified in the Law for the PMDA.

## [You cannot receive vaccination if you have any of the following conditions.]

1. Overt fever (over 37.5℃)
2. Confirmed presence of serious acute disease.
3. Previous episode of anaphylaxis to influenza vaccine.

If you have ever experienced anaphylaxis to any other drug, please tell so to the doctor before vaccination, and the doctor will give you instruction on appropriateness of your receiving the vaccine.

4. Other conditions unsuitable for the vaccination in the opinion of the doctor.

## [You have to seek for doctor's opinion about appropriateness of the vaccination if you have any of the following conditions.]

1. Presence of heart disease, renal disease, hepatic disease, or hematological disease.
2. Children: Developmental retardation managed on guidance of doctor or public health worker.
3. Sings of cold or flu.
4. Previous episode of suspected allergic symptoms, such as fever, rash, and urticaria, occurring within 2 days following vaccination.
5. Previous episode of physical abnormality, such as skin rash, in reaction to any drug or any food(chicken or egg, etc).
6. Previous episode of convulsions.
7. Previous episode of test-proven abnormality of immune function in you or your near relatives.
8. Suspected pregnancy.
9. Presence of bronchial asthma

## [Precautions in post-vaccination management]

1. Side reactions may occur abruptly during 30 minutes after vaccination. You should be alert on occurrence of side reaction and make a contact with a doctor if you notice it. It is advised for you to stay in the medical institution for a while after vaccination to monitor occurrence of side reaction.
2. You can take a bath on the day of vaccination but should not rub the injection site.
3. You are recommended to do usual daily living on the day of vaccination. Please refrain from taking strenuous exercise and heavy drinking of alcoholic beverages.
4. Please consult your doctor immediately in case that abnormal symptoms such as high fever and convulsions occur.

| Immunization Date | Name of hospital |
|---|---|
| month day ( )<br>Please come here at<br>AM/PM : . | Sanno Medical Clinic |

# Checklist for Influenza Immunization

**インフルエンザ予防接種予診票**

For voluntary vaccination
**任意接種用**

**※Please fill out inside bold line ▭ .**
**接種希望の方は、太ワク内にご記入下さい。**

| Temperature 診察前の体温 | ℃ |
|---|---|

| | | | |
|---|---|---|---|
| Address 住　　所 | | TEL. (　　) - | |
| Name 受ける人の氏名 | | Male 男 ・ Female 女 | Date of birth 生年月日 Year 年　Month 月　Day 日 |
| Name of guardian (保護者の氏名) | | | |

| Questions 質 問 事 項 | Answers 回 答 欄 | | Doctor Comment 医師記入欄 |
|---|---|---|---|
| 1.Did you read and understand the explanation of the immunization being given today ? 今日受ける予防接種について説明文(裏面)を読んで理解しましたか。 | No いいえ | Yes はい | |
| 2.Do you give influenza immunization for the first time in the 2006-2007 influenza season. ? 今日受けるインフルエンザ予防接種は今シーズン1回目ですか。 | No( times) いいえ(　回目) | Yes はい | |
| 3.Do you have any concerns about your health today ? 今日、体に具合の悪いところがありますか。 | Yes (please write down details) ある(具体的に) | No ない | |
| 4.Do you have any diseases and are you being treated for ? 現在、何かの病気で医師にかかっていますか。 | Yes(Name of illness) はい(病名) Do you take the medicine?(Yes/No) 薬をのんでいますか(いる・いない) | No いいえ | |
| 5.Within the past month, have you been sick ? 最近1カ月以内に病気にかかりましたか。 | Yes(Name of illness) はい(病名) | No いいえ | |
| 6.Have you ever had, and are you being treated for, any of the following conditions ? :heart or kidney or liver or brood desease, Growth trouble, immunodeficiency syndrome, etc 今までに特別な病気(心臓血管系・腎臓・肝臓・血液疾患、免疫不全症、その他の病気)にかかり医師の診察を受けていますか。 | Yes(Name of illness) いる(病名) | No いない | |
| 7.Has your close relative ever been diagnosed with a congenital immunodeficiency ? 近親者に先天性免疫不全と診断された方がいますか。 | Yes はい | No いいえ | |
| 8.Have you ever had convulsions ? 今までにけいれん(ひきつけ)をおこしたことがありますか。 | Yes( times) ある　回ぐらい At what age (　year　months ) 最後は　年　月ごろ | No ない | |
| 9.Have you ever had an allergic reaction after receiving medicine or eating a particular food(chicken or egg, etc) ? 薬や食品(鶏肉、鶏卵など)で皮膚に発疹やじんましんがでたり、体の具合が悪くなったことがありますか。 | Yes(Name of Medicine or Food) ある(薬または食品の名前) | No ない | |

| | | | |
|---|---|---|---|
| 10.Have you ever been diagnosed with a bronchial asthma and are you bieng treated for ?<br>これまで気管支喘息と診断され、現在、治療中ですか。 | Yes( year months)<br>はい 年 月ごろ<br>Are you being treated?(Yes/No)<br>(現在治療中･治療していない) | No<br>いいえ | |
| 11.Have you ever felt ill after receiving an inoculation ?<br>これまでに予防接種を受けて特に具合が悪くなったことがありますか。 | Yes(Name of the immunization and condition. )<br>ある(予防接種名･症状: ) | No<br>な い | |
| 12.Within the past month, have you been in contact with someone who had measles rubella, chicken pox or mumps ?<br>1カ月以内に家族や周囲で麻しん、風しん、水痘、おたふくかぜなどにかかった方がいますか。 | Yes(Name of illness )<br>ある(病名) | No<br>な い | |
| 13.Within the past month, have you received an immunization ?<br>1カ月以内に予防接種を受けましたか。 | Yes(Name of immunization )<br>はい<br>(予防接種名: ) | No<br>いいえ | |
| 14.(Women only) Are you pregnant ?<br>(ご婦人の方に)現在妊娠していますか。 | Yes<br>はい | No<br>いいえ | |
| 15.(Children only)<br>Were there any unusual conditions at/after birth or at regular well-baby check-up ?<br>(接種を受けられる方がお子さんの場合)<br>分娩時、出生時、乳幼児健診などで異常がありましたか。 | Yes(If yes, please write down details )<br>ある(具体的に) | No<br>な い | |
| 16.If you have anything to inform about your health, please write down details.<br>その他、健康状態のことで医師に伝えておきたいことがあれば、具体的に書いて下さい。 | | | |

To be complete by the Doctor.
**医師の記入欄**
Due to the result of the questionnaire and medical examination, today's immunization will be ( given / postponed )
以上の問診及び診察の結果、今日の予防接種は(可能･見合わせる)
Doctor's signature
**医師の署名**_____

| | |
|---|---|
| After hearing the examination and explanation of effect and adverse reaction on vaccination by the doctor, are you willing to give immunization ? ( Yes / No )<br>医師の診察･説明を受け、予防接種の効果や副反応などについて理解した上で、接種を希望しますか。<br>(接種を希望します･接種を希望しません) | Signature(If children, sign gauardian)<br>保護者の署名(もしくは本人の署名) |

| Vaccine given<br>使用ワクチン名 | | Dosage<br>用法･用量 | Vaccination site, doctor and date<br>実施場所･医師名･接種日時 |
|---|---|---|---|
| Influenza HA Vaccine<br>インフルエンザHAワクチン<br>Lot. No.<br>Lot. No. | | Hypodermic inoculation<br>皮下接種<br>mL | Vaccination site 千代田区永田町2-11-1-2513<br>実施場所 医療法人社団松伯会 山王クリニック<br>Doctor<br>医師名 鈴木 努 Tsutomu SUZUKI, M.D., Ph.D.<br>Date<br>接種日時 年 Month 月 Day 日<br>Hour 時 Minute 分 |
| Chart No.<br>カルテNo. | | | |