新型コロナワクチン接種の予診票（1回目）

※太枠内にご記入またはチェック☑を入れてください。

※左隅に合わせ、点線に沿ってまっすぐに貼り付けてください

（クーポン貼付）

接種会場で貼り付けします

Address	都道府県　市区町村		
Name		Phone #	( ) –
Birthday	□□□□ Year □□ Month □□ Day （満 □□□ Age）	□ ♂ ・ □ ♀	Body temperature before leaving home □□.□ ℃

質問事項	回答欄		医師記入欄
Is this your first time receiving the COVID-19 vaccine? (If no, when did you receive your shot? 1st shot： month 月 day 日、 2nd shot： month 月 day 日)	□ YES	□ NO	
Does the address on the vaccination ticket match your current address?	□ YES	□ NO	
Do you understand the effects and possible reactions to the COVID-19 vaccine?	□ YES	□ NO	
Are you part of the COVID-19 vaccine first priority group? □ Health worker □ 65 and older □ 60 ~ 64 □ Staff employed at elderly care facilities □ Underlying medical conditions (name of condition:)	□ YES	□ NO	
Are you currently receiving medical treatment for underlying medical conditions? Name of condition: □ Heart disease □ Kidney disease □ Liver disease □ Blood disorder □ Hemophilia □ Immuno-compromised □ Other ( ) Treatment method: □ Anticoagulant medication (blood thinners) ( ) □ Other ( )	□ YES	□ NO	
If you receive treatment for an underlying medical condition, did you receive permission from your doctor to receive the vaccine?	□ YES	□ NO	
Did you have a fever or get sick within the past month? Name of illness:( )	□ YES	□ NO	
Do you feel sick or unwell today? Symptoms ( )	□ YES	□ NO	
Did you ever have a seizure before?	□ YES	□ NO	
Did you ever have a serious allergic reaction (anaphylactic shock, etc.) to any medication or food before? If yes, write what caused the reaction ( )	□ YES	□ NO	
Has your condition ever worsened after receiving a vaccination? Vaccine type ( ) Symptoms ( )	□ YES	□ NO	
Are you pregnant or possibly pregnant (late period, etc.), OR are you currently breastfeeding?	□ YES	□ NO	
Have you received the vaccine in the past 2 weeks? Type: ( ) Date of shot ( )	□ YES	□ NO	
Do you have any questions about today's COVID-19 vaccination?	□ YES	□ NO	

医師記入欄		医師署名又は記名押印
医師記入欄	以上の問診及び診察の結果、今日の接種は（ □ 可能 ・ □ 見合わせる ） 本人に対して、接種の効果、副反応及び予防接種健康被害救済制度について、説明した。	

COVID-19 vaccination consent

Upon understanding the effects and possible reactions of the COVID-19 vaccine, and receiving permission from your doctor to receive the vaccine, do you wish to receive the COVID-19 vaccine? (□ I want to receive the vaccine ・ □ I do NOT want to receive the vaccine)

This health questionnaire is to help promote vaccination safety.

I understand the above statements and agree to provide this questionnaire to my municipality's health insurance department.

year 年　month 月　day 日　Signature _____

（※自署できない場合は代筆者が署名し、代筆者氏名及び被接種者との続柄を記載）
（※被接種者が成年被後見人の場合は本人又は成年後見人自署）

医師記入欄	ワクチン名・ロット番号	接種量	実施場所・医師名・接種年月日　※医療機関等コード・接種年月日は枠内に収まるよう記入してください。
	シール貼付位置 ※枠に合わせてまっすぐに貼り付けてください （注）有効期限が切れていないか確認	□.□ ml	実施場所 医師名 医療機関等コード 接種年月日　※記入例）4月1日→04月01日 2 0 2 □ 年 □□ 月 □□ 日