How to Fill Out Screening Questionnaire

Fill in all the red blanks, and fill in the yellow blanks as necessary.

Enter your Appointment Number (2 alphabets + 8-digit number) in the blank space in the upper right corner of the Screening Questionnaire.

Address on the resident card	Prefecture City
	Address
Furigana	
Name	
Date of birth	Year ／ Month ／ D

Take your temperature on the morning of your appointment and enter it here.*
***No vaccination is given if the temperature is 37.5 ℃ or higher.**

Body temperature before examination: __ __ . __ Degrees Celsius

Question	Response field		Field filled in by doctor
Have you ever received the COVID-19 vaccine before? (If yes, date of 1st dose: YYYY/ MM/ DD, date of 2nd dose: YYYY/ MM/ DD) (Vaccine)	☐ YES	☐ NO	
Is the city, town, or village where you currently reside the same as the city, town, or village stated on the coupon?	☐ YES	☐ NO	
Have you read the "Instructions for the COVID-19 vaccine" and do you understand the effects and adverse side effects?	☐ YES	☐ NO	
Are you currently suffering from any kind of illness and receiving treatment or medication? Name of disease: ☐heart disease ☐kidney disease ☐liver disease ☐blood disease ☐disease that makes it difficult to stop bleeding ☐immune deficiency ☐capillary leak syndrome ☐other ( ) Nature of treatment: ☐blood-thinning medicine ( ) ☐ other ( )	☐ YES	☐ NO	
Have you had a fever or gotten sick in the last month? Name of disease ( )	☐ YES	☐ NO	
Are there any parts of your body that are not feeling well today? Condition ( )	☐ YES	☐ NO	
Have you ever had a convulsion (seizure)?	☐ YES	☐ NO	
Have you ever experienced severe allergic symptoms (such as anaphylaxis) from medications or foods? Medication or food that caused the problem ( )	☐ YES	☐ NO	
Have you ever been sick after receiving a vaccine? Type of vaccine ( ) Condition ( )	☐ YES	☐ NO	
Is there any possibility that you are currently pregnant (for example, your period is later than expected)? Or are you breastfeeding?	☐ YES	☐ NO	
Have you had any vaccines within the last two weeks? Type of vaccine ( ) Date of vaccine ( )	☐ YES	☐ NO	
Do you have any questions about the vaccine today?	☐ YES	☐ NO	

For doctors use only	In light of the results of the questions above and examination, today's vaccine is (☐possible, ☐not possible). I have explained the effects of the vaccine, side effects, and the Relief System for Injury to Health with Vaccination to the patient.	Signature and seal of doctor

For Medical institution use only: ◯outside the doctor's hour (time in :) ◯non-consultation day ◯child (under 6) ◯spare① ◯spare②
*Please check by blacking in the appropriate circle

COVID-19 Vaccination Request Form

After receiving a medical examination and explanation from a doctor and understanding the effects and side effects of the vaccine, do you wish to receive this vaccine? (☐ I wish to be vaccinated/ ☐ I do not wish to be vaccinated)

The purpose of this preliminary medical examination form is to ensure the safety of the vaccine.

I understand this and consent to this Pre-Vaccination Screening Questionnaire being submitted to the municipal government, the All-Japan Federation of National Health Insurance Organizations, and the National Health Insurance Organization.

Date: YYYY/ MM/ DD Signature of vaccinated person or their guardian

(*If the person to be vaccinated is unable to sign the form by himself/herself, a representative must sign the form, and the representative's name and relationship to the person to be vaccinated must be indicated.)

(*In the case of a person under 16 years of age, the form must be signed by the guardian; in the case of an adult ward, the form must be signed by the person himself/herself or the adult guardian.)

Field filled in by doctor

Name of vaccine and lot number	Inoculation amount	Vaccination location, name of doctor, and date of vaccination *Please fill in the medical institution code and vaccination date so that they fit within this field.
Seal position *Paste seal upright to align with the edges of the frame. (Note: Make sure that the expiration date has not expired.)	__ . __ ml	Vaccination location Medical institution code — — — — — — — — — — Name of doctor Date of vaccination *Example: April 1, 2021 →2021/04/01 YYYY / MM / DD