Preliminary Examination Form for COVID-19 Vaccination

Fill in or ☑ check the boxes in the section outlined in bold.

Address Registered on Your Residence Certificate (*Juminhyo*):

Name:

Phone No.:

Line up the top left corner, and attach straight along the dotted line.

(Attach vaccination ticket here)

Date of Birth: ☐☐☐☐ Y ☐☐ M ☐☐ D

Years old ☐☐☐

Sex: ☐ M ☐ F

Temp. before Visit: ☐☐ . ☐ °C

Questions	Response Section		For Doctor Use
Is this your first COVID-19 vaccination? If you have received it before… Date of 1st Injection: Date of 2nd Injection:	☐ **Yes**	☐ **No**	
Is the address registered on your residence certificate (*juminhyo*) still in the same municipality shown on the vaccination tickets?	☐ **Yes**	☐ **No**	
Have you read the explanation of the COVID-19 vaccine, and do you understand the effects, adverse reactions, etc.?	☐ **Yes**	☐ **No**	
Do you fall under any of the following priority vaccination groups? ☐Medical professional ☐Age 65 or older ☐Age 60–64 ☐Employee at facility for the elderly, etc. ☐Have an underlying disease (Disease:)	☐ **Yes**	☐ **No**	
Are you currently receiving treatment (medication, etc.) for any disease(s)? Disease(s): ☐Heart disease ☐Kidney disease ☐Liver disease ☐Blood disease ☐A disease that prevents bleeding from stopping ☐Immune system deficiency ☐Other ( ) Treatment: ☐Blood-thinning medicine ( ) ☐Other ( )	☐ **Yes**	☐ **No**	
Has the doctor you see for this disease told you that it is safe to be vaccinated today?	☐ **Yes**	☐ **No**	
Have you had a fever or illness in the past month? Disease: ( )	☐ **Yes**	☐ **No**	
Do you feel physically unwell today? Symptoms: ( )	☐ **Yes**	☐ **No**	
Have you ever experienced convulsions/spasms?	☐ **Yes**	☐ **No**	
Have you ever had a severe allergic reaction (e.g. anaphylaxis) to drugs or foods? Drug, food, or other cause: ( )	☐ **Yes**	☐ **No**	
Has a vaccination ever made you feel unwell? Vaccination: ( ) Symptoms: ( )	☐ **Yes**	☐ **No**	
Is it possible that you might be pregnant (e.g. late menstruation)? Or are you breastfeeding?	☐ **Yes**	☐ **No**	
Have you been vaccinated in the past two weeks? Vaccination: ( ) Symptoms: ( )	☐ **Yes**	☐ **No**	
Do you have any questions about today's vaccination?	☐ **Yes**	☐ **No**	

For Doctor Use	Based on the above interview and an examination, the patient for vaccination (☐can / ☐cannot) receive a vaccination today. The effects of the vaccine, adverse reactions, and the Relief System for Injury to Health with Vaccination have been explained to the patient.	Doctor's Signature or Name and Seal

Application for COVID-19 Vaccination

Have you received a doctor's examination and explanation, do you understand the effects of the vaccine and adverse reactions, and do you wish to receive the vaccine?

☐**I wish to receive the vaccine.** ☐**I do not wish to receive the vaccine.**

This preliminary examination form is intended to ensure the safety of vaccinations.

Based on this understanding, I agree to submit this preliminary examination form to the municipality, the All-Japan Federation of National Health Insurance Organizations, and the Federation of National Health Insurance Associations.

Date: _____, 20__

Signature of patient receiving vaccine_____

(If the patient cannot sign on their own, write in the proxy's name and relationship to the patient.)
(If the patient is an adult ward, the patient or the patient's guardian shall sign on their own.)

For Doctor Use

Vaccine Name and Lot Number	Dose	Location, Name of Doctor, and Date of Vaccination (Write the medical institution code and date of vaccination in the spaces below.)
Attach Sticker Here * Attach the sticker straight in the space. Note: Make sure that the vaccine has not expired.	☐ . ☐ ml	Location Name of Doctor Medical Institution Code ☐☐☐☐☐☐☐☐☐☐ Date of Vaccination Example: April 1 → 04 01 2 0 2 ☐ ☐☐ ☐☐