Name of Vaccination Facility：Japanese Quarantine Association Tokyo Clinic

整理番号

Date(Day/Month/Year)

Vaccination Inquiry

/ /20

※Please fill inside the bold line

Name (Passport Name)		Phone Number/Emergency Number
Address	〒 ー	Name of parent/guardian Only for the use of minors

Date of Birth(D/M/Y)	Age	Gender	Nationality
/ /		☐Male ☐Female	

Occupation		Destination	
Departure	/ / 20	Duration	For days
Purpose	Business / Sightseeing / Study Other( )	Yellow Fever Vaccination	☐First time ☐( )times
Body Temperature	. ℃	Today's condition	☐Good ☐Not Good

Please check the box if any of the following disease or treatment applies to you. If you do not have any, check "None".

☐Fever ☐Renal Disease ☐Diabetes ☐Heart Disease ☐Liver Disease ☐Common Cold
☐Asthma ☐Skin Disease ☐Blood Disease ☐Immune deficiency syndrome ☐Dental Disease
☐Nervous system disorder ☐Others( ) ☐None

If any of the above is applicable to you, did your doctor give you the permission to receive the vaccine today?	☐Yes ☐No
Have you ever been diagnosed as immune deficiency syndrome before?	☐Yes ☐No
Do you take any medicine? (e.g., cortisone, anticancer drug, biological products, etc.)	☐Yes ☐No
Name of medication:	
Have you ever been hospitalized for any medical treatment?	☐Yes ☐No
Describe details:	
Did you have any of the following illness in the past 4 weeks? Measles, Rubella, Chickenpox, Mumps or Influenza	☐Yes ☐No
Has anyone in your family or colleague (for infant, playmate) suffered from Measles, Rubella, Chickenpox, Mumps or other infectious diseases in the past 1 month?	☐Yes ☐No
Have you received blood transfusion, plasma or γ-globulin in the past 3 months?	☐Yes ☐No
Did you have any of the following vaccination in the past 4 weeks?	☐Yes ☐No

☐Hepatitis A(/) ☐Hepatitis B(/) ☐Tetanus(/) ☐Rabies(/) ☐Japanese encephalitis(/)
☐Typhoid(/) ☐Diphtheria(/) ☐Meningitis(/) ☐Polio(/) ☐Influenza(/)
☐Cholera(/) ☐Measles(/) ☐Rubella(/) ☐Measles/Rubella(MR)(/)
☐Combined vaccine(Diphtheria-Pertussis-Tetanus)(/) ☐Combined vacccine(Diphtheria-pertussis-tetanus-polio)(/)
☐Chickenpox(/) ☐Mumps(/) ☐Pneumococcus(/) ☐Others( )(/)

Are you allergic to egg or chicken,gelatin product or any foods ?	☐Yes ☐No
Have you ever experienced redness of skin caused by ethanol used as disinfection?	☐Yes ☐No
Are you allergic to any drug or vaccination?	☐Yes ☐No
Is your family allergic to any drug or vaccination?	☐Yes ☐No
(Women Only) Are you currently pregnant, possibly pregnant or breast feeding?	☐Yes ☐No

※Flip over and fill in the other side

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※Fill in below if the vaccine is a minor.

Age (Year and Month)	year(s) month(s) old	
Birth weight/Birth weeks	Birth weight( ) g ／Birth Week( ) weeks	
Did your child have any abnormality during the delivery?		☐Yes ☐No
Does your child have any abnormality such as developmental delay?		☐Yes ☐No
Did your child have any convulsions in the past one year?		☐Yes ☐No
Does any of your child be diagnosed as congenital immune deficiency?		☐Yes ☐No

医師記入欄

○診察所見（視診・咽頭所見・心音・触診・その他身体的所見）

特記すべき事項（ なし ・ あり ）※ありの場合は以下に詳細を記載。

＜接種情報＞

ワクチン名： YF-VAX

メーカー名： Sanofi Inc.

用法・用量： 0.5mL 皮下注射

ロット番号：

使 用 期 限：

接 種 部 位： ☐左腕 ☐右腕 ☐その他( )

＜同時接種＞

問診および診察の結果、本日の予防接種の可否 ☐可 ☐不可

接種日・接種時間

20 年 月 日 ：

担当医師の署名

I understood the information given to me about immunization, result of medical examination and caution for after vaccination. I request that myself, or the above named child, be immunized with the recommended vaccine.

Signature (For minors, signature of the parent or guardian)

(2019/7作成)