The Covid-19 vaccine is free

When you get the vaccine, please bring this form and the Prevaccination Screening Questionnaire with you.

This document is proof of your 3rd vaccine dose, so please do not lose it.

新型コロナウイルスワクチン　予防接種済証（臨時接種)

Certificate of Vaccination for COVID-19

Vaccination Number :

3rd Dose		Manufacturer/ Lot No. (Sticker)	Name	
Date			Address	
	Year			
Month	Day			
Place			Date of Birth	

Record of 1st and 2nd Vaccine Doses

	1st Dose	2nd Dose
Vaccination Date		
Manufacturer		
Lot NO.		
Place		

※ For areas marked with * records will be shown via additional certificates or records provided by the vaccine administrator.

Prevaccination Screening Questionnaire for COVID-19 vaccine (for the 3rd Dose)

*Please fill in or check the ☑ boxes inside the bold frame

Address on your juminhyo	Prefecture	City		**You CANNOT SUBMIT this English questionnaire. Please fill in your answers on the Japanese questionnaire and bring them with you.**	
Furigana / Name		Tel. No.			
Date of birth	____ Year __ Month __ Date (___ yrs old)	□ Male □ Female		Body temperature before examination	––.– °c

Question	Response field		Field filled in by doctor
Have you gotten the vaccine before? Vaccination Date (1st shot : __Y __M __D, 2nd shot : __Y __M __D) Vaccine type ( )	□ yes	□ no	
Is the city, town, or village where you currently reside the same as the city, town, or village stated on the ticket?	□ 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	

Field filled in by doctor	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

Field filled in by medical institutions	

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 接種を希望します **□ I do not wish to be vaccinated)** 接種を希望しません

The purpose of this preliminary medical examination form is to ensure the safety of the vaccine.
I understand this and consent to this prevaccination Screening Questionnaire being submitted to the municipal government, the All-Japan Federation of National Health Insurance Organizations, and the National Health Insurance Organization.

Date : ____Y / __M /__D

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 it straightly along 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 2 0 2 □ Y □□ M □□ D