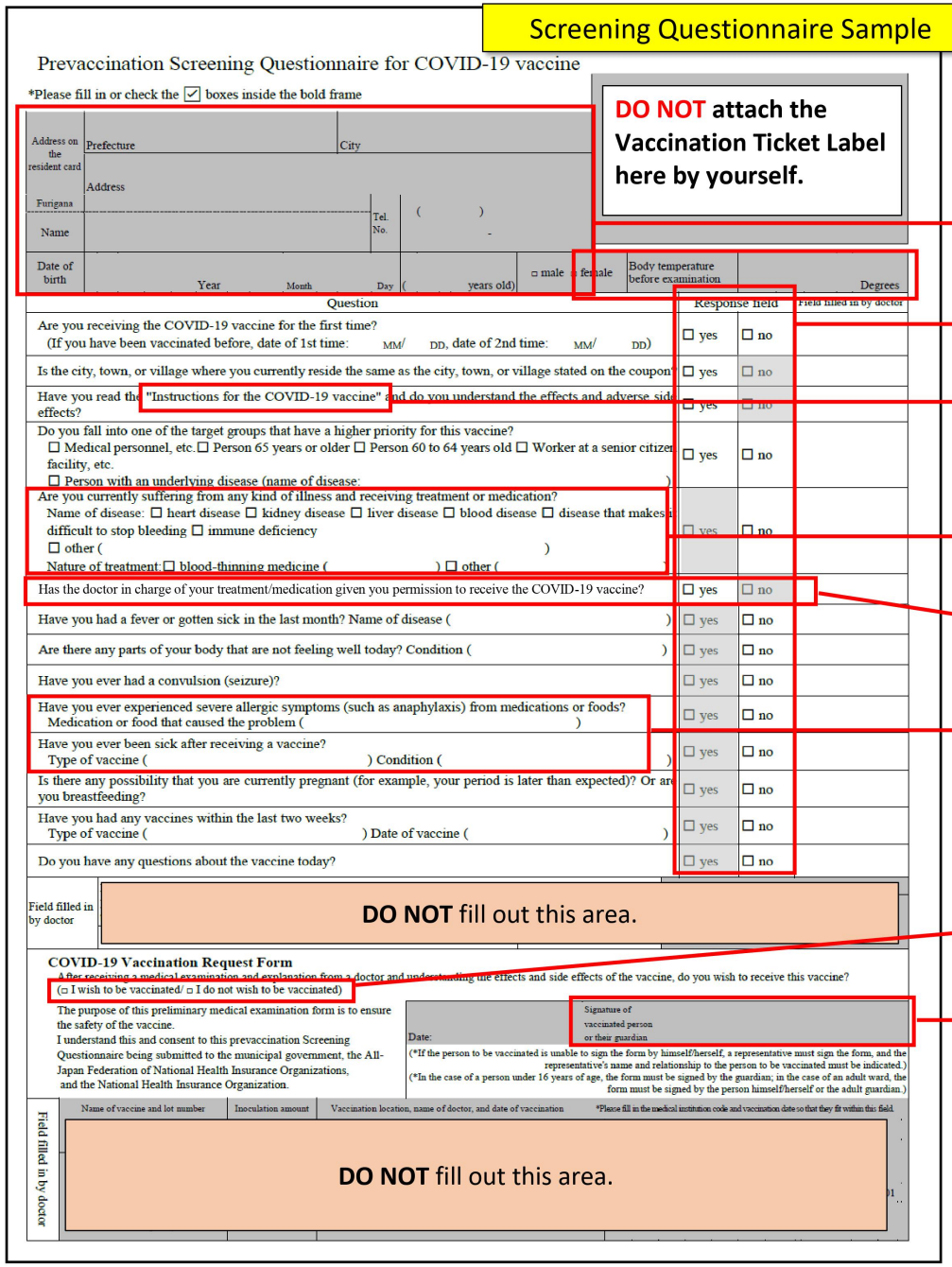
【COVID-19 Prevaccination Screening Questionnaire Sample 】 If you are unsure about any medical conditions you might have, please consult with your doctor.

Note： You cannot submit this English questionnaire. Please fill out your answers on the Japanese questionnaires and bring them with you.



Screening Questionnaire Sample

Prevaccination Screening Questionnaire for COVID-19 vaccine

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

DO NOT attach the Vaccination Ticket Label here by yourself.

Address on the resident card / Prefecture / City / Address / Furigana / Name / Tel. No. ( ) -

Date of birth Year Month Day (years old) □ male □ female

Body temperature before examination Degrees

Question	Response field		Field filled in by doctor
Are you receiving the COVID-19 vaccine for the first time? (If you have been vaccinated before, date of 1st time: MM/ DD, date of 2nd time: MM/ DD)	☐ 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	
Do you fall into one of the target groups that have a higher priority for this vaccine? ☐ Medical personnel, etc. ☐ Person 65 years or older ☐ Person 60 to 64 years old ☐ Worker at a senior citizen facility, etc. ☐ Person with an underlying disease (name of disease:)	☐ 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 ☐ other ( ) Nature of treatment: ☐ blood-thinning medicine ( ) ☐ other ( )	☐ yes	☐ no	
Has the doctor in charge of your treatment/medication given you permission to receive the COVID-19 vaccine?	☐ 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 — **DO NOT** fill out this area.

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 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: 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.)

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.

Field filled in by doctor — **DO NOT** fill out this area.

Please check the address and date of birth listed in the "Certificate of Vaccination for COVID-19" section of the Vaccination Ticket Form. Please write the address registered in your Address Registry (Juminhyo), your date of birth (Gregorian Calendar), and your age on the date of vaccination.

Please check ☑ "Yes (はい)" or "No (いいえ)" for your answers.

Please make sure to read the enclosed Explanation Form.

If you are currently receiving medical treatment, please make sure to confirm your medical information with your doctor first.

If you answer "No," you may not be able to get the vaccine.

If you are unsure about your allergic reactions, please consult with your doctor or pharmacist.

Please check ☑ the "I wish to get vaccinated (接種を希望します)" box.

Please sign here to indicate your agreement to the questionnaire conditions. If you cannot sign for yourself, you can have someone sign for you, and have them also right their full name and relationship to you in the box.

★Please check if there are any areas you have missed.