

## Influenza Vaccination Preliminary Questionnaire

Please fill in this form if you wish to receive influenza vaccination

Body temperature before examination	.....°C
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Address	.....	TEL: .....	
Name of vaccine recipient	.....	Sex	Male      Female
(Name of guardian)	.....	Date of Birth: Year	Month      Day
		...../...../.....	
		Age: ..... years old	

Questions	Answers		Physician's comment
1-Have you read the explanation about the vaccination you are about to receive today and understood its effect and potential side effects?	No	Yes	
2-Including today's vaccine, How many times have you received influenza vaccine this season?	1 time	2 times	
3-(If the recipient is a child) Please answer the following questions about the developmental history of the child:			
*Were there any abnormalities during delivery?	Yes	No	
*Were there any abnormalities after birth?	Yes	No	
*Were there any abnormalities found at infant checkups?	Yes	No	
4-Have you ever felt sick after receiving a non-influenza vaccination?	Yes	No	
*Name of vaccination: .....			
5-Have you ever been diagnosed with a significant disease (congenital disorder, disease of the heart, kidney, or liver, neurological disease, immunodeficiency, blood disease, etc.)?	Yes	No	
6-Have you ever had a seizure (convulsions)?	Yes	No	
7-Have you ever been diagnosed with interstitial pneumonia, bronchial asthma, or other types of respiratory diseases?	Yes	No	
8-Have you ever developed a rash or hives or became sick due to a medication or food (particularly, a chicken egg or meat, chicken-derived ingredients)?	Yes	No	
9-Have any of your close family members become sick after a vaccination?	Yes	No	
10-Do you have a close family member with congenital immunodeficiency?	Yes	No	
11-(If you are a woman) Are you currently pregnant?	Yes	No	
12-If you have anything else you would like to share with your physician regarding your health condition please fill in here. .....			

To be filled out by the physician	To be filled out by the recipient (or guardian)
On the basis of the above inquiry and examination, I conclude that the recipient ( can receive / should not receive ) the vaccination today. <b>Physician' signature or name / seal:</b> .....	I understood the effect, purpose, and potential side effects of the vaccination, I ( agree / do not agree ) to receive the vaccination.  Signature:..... Representative relationship .....

Name of vaccine used	Dosage	Facility, physician name and time of vaccination
Name: Influenza HA Vaccine	Subcutaneous injection	Facility: .....
O Biken HA Vaccine      O Flubik HA Syringe	<input type="checkbox"/> 0.25ml (6 months old up to 3 years old)	Physician name .....
Lot No.	<input type="checkbox"/> 0.5ml (Above 3 years old)	Time of vaccination
Manufacturer: The Research Foundation for Microbial Diseases of Osaka University		HH;MM ..... .....
Tanabe Mitsubishi Pharma, Co.Ltd		Month/Day/Year ...../...../.....

# Please Read Before You Request Influenza HA Vaccination

## 1. Influenza and complications

Influenza is a respiratory infection with the influenza virus that spreads by air and hands when a patient coughs and sneezes. In 1 to 5 days after a person is infected, some symptoms begin to appear, including tiredness, sudden fever, sore throat, coughing, and sneezing, which normally disappear in about a week. However, in the case of an elderly person, a baby, a person with a weakened immune system, or an adult with less physical strength, close monitoring is necessary because serious complications (such as pneumonia, death, etc.) are possible.

## 2. Effect and side effects of influenza vaccine

The effect of the vaccine has long been debated. The vaccination is expected to shorten the symptoms even if you catch the flu. It is also expected to prevent the symptoms from becoming severe enough to require hospitalization.

The side effects of the vaccine include a fever as well as redness, swelling, and induration at the injection site. Approximately, several persons out of 100 would experience a fever; and one person out of 10 would experience redness and swelling. In rare cases, the following side effects may occur: (1) shock, anaphylaxis (hives, difficulty breathing, angioedema, etc.); (2) acute disseminated encephalomyelitis (a fever, headaches, impaired mobility, impaired consciousness, etc. after several days to 2 weeks of vaccination); (3) encephalitis, encephalopathy, myelitis, optic neuritis; (4) Guillain-Barre syndrome (numbness in arms and legs, disturbance of gait, etc.); (5) seizures (including fever convulsions); (6) liver function impairment, jaundice; (7) asthmatic attack; (8) thrombocytopenic purpura, decrease in platelets; (9) vasculitis (allergic purpura, allergic granulomatous angiitis, leukocytoclastic vasculitis, etc.); (10) interstitial pneumonia; (11) mucocutaneous ocular syndrome (Stevens-Johnson syndrome); (12) nephrotic syndrome.

## 3. You should not receive influenza vaccination, if any of the following is true:

- 1) You clearly have a high fever (typically above 37.5°C).
- 2) You currently have a severe and acute disease.
- 3) You have experienced anaphylaxis (severe allergic reactions that typically appear within 30 minutes after a vaccination, that include difficulty breathing, severe full body hives, etc.) due to any component of this vaccine.
- 4) Your physician has advised you not to receive the vaccination.

## 4. You should consult your physician before receiving influenza vaccination, if any of the following is true:

- 1) You have an underlying condition such as a cardiovascular disease, kidney disease, liver disease, blood disease, etc.
- 2) You have had a rash or other abnormalities due to a medication or food (a chicken egg or meat, etc.)
- 3) You have a history of seizures (convulsions).
- 4) You have experienced a fever, full body rash, hives and other symptoms that appear to be allergic reactions within 2 days of an influenza vaccination.
- 5) You have previously been diagnosed with an immune disorder or have a close family member with a congenital immunodeficiency.
- 6) You have a respiratory illness such as interstitial pneumonia, bronchial asthma, etc.
- 7) You are pregnant.
- 8) You were born prematurely and your physical growth is slow (if you are a child).
- 9) Your physical growth is slow, and you are receiving care from your physician and public health nurse (if you are a child).

**5. Please take the following precautions after influenza vaccination:**

- 1) Some allergic reactions (difficulty breathing, hives, coughing, etc.) may occur during the first 30 minutes after the vaccination. Be prepared to contact a physician immediately.
- 2) Many of the side effects (a fever, headache, seizures, etc.) are known to appear within 24 hours. Monitor your physical condition closely for a full day after the vaccination. If you happen to experience a high fever, seizures, or any other abnormalities, consult a physician immediately.
- 3) After the vaccination, you may experience redness, swelling, or pain at the site of vaccination, which normally subside within 4 to 5 days. If you notice any change in your physical condition, consult a physician immediately.

<b>Appointment for vaccination</b>	<b>Name of facility</b>
MM/DD: (..... ..) Please arrive by: HH:MM: .....: .....	.....

