Name of Vaccination Facility：KOBE Quaratine Station

受付番号	接種時間

Yellow Fever Vaccination Inquiry

Date(Day/Month/Year)
/ /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	
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 ever had a thymus disease, including myasthenia gravis, or a thymectomy?	☐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(/) ☐Pneumococcus(/) ☐Meningitis(/) ☐Polio(/) ☐Influenza(/)
☐Cholera(/) ☐Measles(/) ☐Rubella(/) ☐Measles/Rubella(MR)(/)
☐Combined vaccine(Diphtheria-Pertussis-Tetanus)(/) ☐Combined vacccine(Diphtheria-pertussis-tetanus-polio)(/)
☐Chickenpox(/) ☐Mumps(/) ☐COVID-19(/ , /) ☐Others( )(/)

Are you allergic to eggs, chicken, gelatin product , other foods, metal or pollen?	☐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**

Name of Vaccination Facility：KOBE Quaratine Station

※Fill in below if the vaccinee 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

〇診察所見（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®	ロット番号：	
メーカー名：	Sanofi,Inc	使用期限：	
用法・用量：	0.5mL 皮下注射	接種部位：	☐左腕 ☐右腕 ☐その他（　　　）
ロット番号：			

《同時接種情報》

ワクチン名：		ロット番号：	
メーカー名：		接種回数：	☐初回 ☐2回目以降（　回目） ☐追加
用法・用量：	☐皮下注射 ☐筋肉内注射 ☐経口投与　ml	接種部位：	☐右腕 ☐左 腕 ☐その他（　　　）

ワクチン名：		ロット番号：	
メーカー名：		接種回数：	☐初回 ☐2回目以降（　回目） ☐追加
用法・用量：	☐皮下注射 ☐筋肉内注射 ☐経口投与　ml	接種部位：	☐右腕 ☐左 腕 ☐その他（　　　）

ワクチン名：		ロット番号：	
メーカー名：		接種回数：	☐初回 ☐2回目以降（　回目） ☐追加
用法・用量：	☐皮下注射 ☐筋肉内注射 ☐経口投与　ml	接種部位：	☐右腕 ☐左 腕 ☐その他（　　　）

・以上、問診及び診察の結果、本日の予防接種の可否　☐可　☐不可

・予防接種に対する被接種者又は保護者の同意　☐得られた　☐得られなかった

接種日・接種時間

20　　年　　月　　日　　　：

担当医師の署名

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)