

Consent form for Influenza Vaccine (Fiscal year 2024)

Please print your answers in the spaces provided below.

Address:		Body temperature before examination °C	
Name:	Male · Female	TEL:	
Company / Organization:	Date of Birth: (yyyy/mm/dd)	Age:	
Employee number:			
Health Insurance Provider:	Insurance Card Number:		

	Questions	Answers	Physician's Notes
1	Have you read information on influenza vaccinations provided on the back of this form?	Yes · No	
	Do you have any diseases now? Specify the disease name(s) ()	Yes · No	
	Are you receiving any treatments (Medicines, etc.)?	Yes · No	
2	Have you ever been diagnosed to have certain diseases such as birth defects, heart diseases, kidney diseases, liver diseases, blood diseases, cranial nerve disease, immunodeficiency diseases, or malignant tumors. Specify () If yes, did your physician approve today's vaccination?	Yes · No	
3	Have you or anyone of your family been diagnosed with congenital immunodeficiency diseases?	Yes · No	
4	Is there anything unusual about your condition today? If yes : Specify your symptoms. ()	Yes · No	
5	Have you had any fever or illness during the past 1 month? Specify the disease name(s) ()	Yes · No	
6	Has anyone of your family or those close to you contracted influenza, measles, rubella, chickenpox or mumps during the past 1 month? Specify the disease name(s) ()	Yes · No	
7	Have you had any vaccinations during the past 1 month?	Yes · No	
	Specify the type of vaccination(s) ()		
8	Do you have any respiratory diseases such as interstitial pneumonia or bronchial asthma and are currently under medical treatment?	Yes · No	
9	Have you ever received influenza vaccination before?	Yes · No	
	①Have you ever experienced any adverse effects from influenza vaccination?	Yes · No	
	If yes, please specify your actual symptoms. ()		
10	②Have you ever had any allergic reactions to any vaccinations?	Yes · No	
	Specify the name of vaccination(s) ()		
	Have you ever had a rash or other reactions to certain medicines or foods (e.g. chicken, eggs)?	Yes · No	
11	Specify the medicine or food ()		
	Have you ever had convulsions? Specify the approximate age of convulsions ()	Yes · No	
	Did you have a fever at the time of convulsion?	Yes · No	
12	Has anyone of your close relatives had any adverse effects from vaccinations?	Yes · No	
13	Do you have any questions regarding today's vaccination?	Yes · No	
	(Women only) Are you currently pregnant or do you think you might be pregnant?	Yes · No	

I have received explanation by the physician and understood the effects, benefits and purposes of this vaccination, and the risks of serious side effects, etc. and **(wish to ; do not wish to)** receive this vaccination.

Date _____ / _____ / _____ Signature of Recipient: _____
 (yyyy/mm/dd)

The Handling of Personal Information (See the back of this form.): Any personal information will only be utilized for the purposes of the vaccination. If you are willing to consent to this, please indicate your agreement.

I agree I disagree

*Please inform us if you disagree.

FOR OFFICE USE ONLY

As a result of the consultation, today's vaccination should be (proceeded ; should be cancelled).
The patient was given an explanation of the effects, benefits, purposes and side effects of this vaccination, and relief system for injury to health with vaccination.
 Signature or seal of physician: _____

Vaccine given	Dosage	Medical Corporation Shinkokai
Lot Number:	mL	Vaccination Site:
		Date(yyyy/mm/dd): / /

Information of the influenza Vaccine(fiscal year 2024)

<Efficacy and side-effects of influenza vaccine >

An influenza vaccination can prevent influenza infection or reduce the severity of symptoms caused by influenza infection. The vaccine also prevents other health complications that can occur as a result of influenza infection, which can potentially lead to severe condition or sometimes death. It is commonly known that vaccination can cause some adverse reactions. Adverse reactions include rash, hives, which can potentially lead to eczema, erythema, erythema multiforme, angioedema and itching sensations. These side effects are uncommon and usually disappear within two or three days. In rare cases, other symptoms such as fever, chills, headache, fatigue, a temporal loss of consciousness, dizziness, swollen lymph nodes, vomiting, stomachache, diarrhea, loss of appetite, arthralgia, myalgia, coughing and palpitation can occur. Adverse reactions at the injection site could be also possible: flare, swelling, hardening of the skin, thermal sense, pain, numbness and phlyctena. These side effects also disappear within two or three days. In addition, cellulitis (suppurative inflammation caused by bacteria), facial paralysis, peripheral neuropathy, faintness, vasovagal reflex, numbness, tremor and uveitis can occur. Please tell our physician if you have a strong allergy to eggs, as serious side effects could occur. In rare cases, the following conditions could occur : (1) Shock, Anaphylactic shock, (hives, severe difficulty in breathing, angioedema, etc.) (2) Acute disseminated encephalomyelitis (a few days-two weeks after vaccination, fever, headache, convulsions, motor control difficulty, loss of consciousness, etc.) (3) Guillain Barre syndrome (numbness in hands and feet, difficulty in walking, etc.) (4) Convulsion (fever-induced convulsion included) (5) Liver function disorder, jaundice (6) Asthma attack (7) Thrombocytopenic purpura, thrombopenia (8) Vasculitis (allergic purpura, allergic granulomatous angitis, leukocytoclastic vasculitis, etc.) (9) Interstitial pneumonia (10) Encephalitis, encephalopathy, myelitis, optic neuritis. (11) Stevens- Johnson syndrome (12) Nephrotic syndrome

The person receiving the vaccine or a family member of the person is responsible for seeking professional medical assistance if a health injury due to vaccination is suspected, and if susceptible, relief services for drug-induced sufferings will be applied.

(The Pharmaceuticals and Medical Devices Agency)

Persons with the following conditions should not be vaccinated:

- 1) Those with fever (higher than 37.5°C / 99.5°F)
- 2) Those with some severe acute disorders
- 3) Those with a history of anaphylactic shock from receiving influenza vaccine (Must inform the physician immediately).
- 4) Those who are not considered to be eligible for preventive vaccination by physicians.
- 5) Those who may be pregnant.
 - Please consult with your Gynecologist or physician.
- 6) Those who are under the age of 16.
 - Please contact your pediatrician for further inquiry.

You must seek medical advice prior to vaccination if you have the following conditions:

- 1) Those with a growth retardation and have been receiving continuous guidance of physicians.
- 2) Those with a initial symptoms of a common cold.
- 3) Those with underlying diseases such as cardiovascular, respiratory, kidney, liver and blood disorders.
- 4) Those with a history of influenza vaccine-related allergic reactions such as fever, rash or hives within 2 days after influenza.
- 5) Those with a history of of convulsions.
- 6) Those who or your close relatives have been diagnosed with immunity disorders in the past.
- 7) Those with a history of interstitial pneumonia or asthma.
- 8) Those with a history of rash or any adverse reactions due to intake of medications or foods.
(eggs, chicken meat intake, etc.)

Precautions after vaccination:

- 1) An acute reaction may occur after influenza vaccination. It is recommended to stay in the clinic for observation about 30 mins after vaccination and if you experience any allergic reactions, consult a physician immediately.
- 2) You can take a bath after vaccination. However, don't rub the injection site.
- 3) Avoid excessive alcohol intake or intense exercise, and keep the injection site clean after vaccination.
- 4) Seek medical advice immediately if you have any abnormal symptoms such as high fever or convulsions.

< Relief Services for Adverse Health Effects> <https://www.pmda.go.jp/english/index.html>

PMDA has "Adverse Drug Reaction Relief System" to compensate for death or health damages requiring hospitalization, caused by appropriately used prescribed and purchased drugs. Shin-Kasumigaseki Building, 3-3-2 Kasumigaseki, Chiyoda-ku, Tokyo 100-0013 Japan

< Purpose of Use of Personal Information >

- 1) Examination and administration for influenza vaccination.
- 2) Reporting of vaccine implementation (Health Insurance Association/Employer/Vaccinated Person)
- 3) Billing processing (Health Insurance Association/Employer/Vaccinated Person)
- 4) Providing statistical information and adverse events to the Relevant government offices.

< Privacy Contact >

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