Preliminary Medical Checkup Sheet for the 5th Stage of Routine Vaccination against Rubella										
Please fill in	lease fill in all the information in the bold boxes. Prefecture City Ward									
Addres		Town Village						(Attach ticket)		
resider certifica										
Name	Male / Female									
Date of b (year/mo /day)		(YYYY) (MM) (DD) (age: yrs.) Body temperature before examination °C								
Questions							Answer column Physician's use only			
Is the city, town, or village listed on your resident certificate the same as the city, town, or village listed on the ticket?						No	Yes			
Have you read the information sheet distributed by your municipality regarding today's vaccination?							Yes			
Do you understand the effects and potential side effects, etc. of today's vaccination?						No	Yes			
Are you currently suffering from any medical conditions? Name of condition (Yes	No			
Are you receiving any treatment (medication, etc.)? Name of treatment (Yes	No			
Has your doctor told you that you can receive the vaccination today?						Yes	No			
Have you ever been diagnosed with immunodeficiency?						Yes	No			
Do you feel unwell in any way today? If so, please describe your symptoms (No			
Have you ever had a skin rash, hives, or other health problems caused by medicines or foods? Name of medicine/food ()						Yes	No			
Have you ever fallen sick after receiving a vaccination? Symptoms () Type of vaccination ()						Yes	No			
Have you ever had a seizure (convulsion)? At what age? yrs.						Yes	No			
Have you received any vaccinations within the past month? Type of vaccination, date of vaccination (No			
Have you ever had a chronic disease such as heart disease, kidney disease, liver disease, or blood disease? Name of condition (Yes	No			
Has the doctor who is treating you for this condition told you that you can receive the vaccination today?						Yes	No			
Have you had a high temperature or been sick at any time in the past month? Name of illness (No			
Do you have any questions about today's vaccination? Yes No										
Based on the results of the antibody test, etc., I have (confirmed / not confirmed) that the individual in question is eligible to stage of routine vaccination against rubella.							gible to receive the 5th			
Physic	cian's use only	Based on the above interview and examination, I judge that the vaccination today can be use only					,			
,	•	I explained the expected effects to the patient.	of the vaccination	on, potential side effe	tial side effects, and the Relief System for Sufferers from Adverse Drug Reactions					
Physician's signature or name and seal										
Consent form for the 5th stage of routine vaccination against rubella (to be filled out after the doctor's examination and judgment that vaccination is possible) Having received a medical examination and explanation from a physician, and having understood the effects and purpose of the vaccination, the possibility of side effects, etc., do you agree to be vaccinated?										
(I agree to be vaccinated / I do not agree to be vaccinated) The purpose of this medical checkup sheet is to ensure the safety of vaccinations. I understand the purpose of this medical checkup sheet and agree to have it submitted to the municipality, the National Health Insurance Central Council, and the										
National Health Insurance Federation.										
Date: (YYYY) (MM) (DD) Signature of person receiving vaccination (*If the applicant is unable to sign the form, a proxy must sign the form and write the his or her name and relationship with the person taking the test.)										
Onse										
Physician's use only	Nan	Name of vaccine used		Place of administration, name of physician, date of examination						
	Name of vaccine	ame of vaccine		Place of administra	dministration: Medical institution etc. c		dical institution etc. code			
	Lot No.	ot No		Name of physician:	sician:					
	Note: Check the	Note: Check that the vaccine is still within the expiration date.		Date of vaccination	: Date: (YYYY)	(MM)	(DD)			