Influenza Vaccination Screening Questionnaire

		Body temperature before exam:	
Address			
Name		Gender:	Male Female
Date of Birth	year: month: day:		(years old)

Question	Answer		Doctor's note
Have you read the instructions/information statement from your municipality regarding the influenza vaccination you are about to get today?	Yes	No	
Have you understood the benefits and potential side effects of today's vaccination?	Yes	No	
Do you currently have any illnesses or medical conditions? Name of Disease ( )	Yes	No	
Are you currently under medical treatment (e.g. medication)?	Yes	No	
Have you received approval from the doctor treating you to receive today's vaccination?	Yes	No	
Have you ever received a diagnosis of immunodeficiency?	Yes	No	
Do you have any symptoms or feel unwell today? If yes, please describe your symptoms ( )	Yes	No	
Do you have any allergies to chicken or eggs?	Yes	No	
Have you ever received an influenza vaccination (flu shot)?	Yes	No	
(a) Did you experience any side effects or complications at that time?	Yes	No	
(b) Have you ever experienced side effects from any vaccines other than the influenza vaccine?	Yes	No	
Have you ever had a seizure (convulsions)?	Yes	No	
Have you received any vaccinations within the past month? Type of vaccination: ( )	Yes	No	
Do you have a history of chronic diseases such as heart disease, kidney disease, liver disease, or blood disorders? Name of disease: ( )	Yes	No	
Has your attending physician given permission for you to receive today's vaccine?	Yes	No	
Have you experienced a fever or any illness within the last month? Name of disease: ( )	Yes	No	
Are there any questions you would like to ask about today's vaccination?	Yes	No	

For Physician Use Only	Based on the screening and examination results, today's vaccination is: ☐ Approved ☐ Deferred I have explained the benefits, potential side effects, and the Relief System for Injury to Health with Vaccination to the vaccine recipient Physician's Signature or Name and Seal: (Seal)

Vaccine Lot Number	Dosage	Location/Physician's Name/Date of Vaccination
Lot No.	mL	Clinic/Facility: Physician's Name: Date of Vaccination: / / (MM/DD/YYYY)

Influenza Vaccine Consent Form

(Please complete this section after the doctor has approved your vaccination)

Do you wish to receive the vaccination after understanding its benefits, purpose, and potential risks of severe side effects explained by the doctor? ☐ Yes ☐ No

This questionnaire is used to ensure the safety of your vaccination

I understand the terms above and consent to the submission of this questionnaire to the municipality

Date (MM/DD/YYYY): _____ / _____ / _____ Vaccine Recipient's Signature: _____

(※ If unable to sign, a legal guardian or representative must sign below and indicate their relationship)