

- ① Postal address as registered in your resident registration (*Jumin-Hyo*)
- ② Full name (and *furigana* in the upper section)
- ③ Phone number
- ④ Date of birth (Year as per Western Calendar)
- ⑤ Age (as of the date of vaccination)
- ⑥ Gender ☐男(Male) ☐女(Female)
- ⑦ Body temperature measured on the day of vaccination
- ⑧ Have you received COVID-19 vaccination before?  
Date of vaccination (1st : YYYY 年 MM 月 DD 日、2nd : YYYY 年 MM 月 DD 日)  
Name of vaccine you received ( )
- ⑨ Is the city written on your vaccination coupon same as the city in which you have a resident registration?
- ⑩ Have you read the explanation on COVID-19 vaccination and understood its effect and side reaction?
- ⑪ Are you under a medical treatment (including medication) now?  
病名(Name of disease) : ☐心臓病 (Heart disease) ☐腎臓病(Kidney disease) ☐肝臓病(Liver disease) ☐血液疾患(Blood disorder) ☐血が止まりにくい病気(Have trouble stopping bleeding) ☐免疫不全(Immunodeficiency)☐毛細血管漏出症候群(Capillary leak syndrome) ☐その他 (Other) ( )  
治療内容(Treatment):☐血をサラサラにする薬(Blood thinner)( )☐その他 (Other)( )
- ⑫ Have you had a fever or contracted a disease within one month?  
Name of disease ( )
- ⑬ Do you feel something is wrong with your condition today? Symptoms ( )
- ⑭ Have you ever had convulsions before?
- ⑮ Have you ever had severe allergic reactions to medications or foods?  
What was the cause? ( )
- ⑯ Have you ever become sick after receiving a vaccination?  
Type of vaccination ( ) Symptoms ( )
- ⑰ Is there a possibility that you are currently pregnant? Or are you breastfeeding?
- ⑱ Have you received any vaccinations within the last two weeks?  
Type of vaccination ( ) Date of vaccination ( )
- ⑲ Do you have any questions about today's vaccination?
- ⑳ Do you want to get vaccinated upon receiving explanation and understanding about the effects and side reactions? (☐接種を希望します(Yes) ☐接種を希望しません (No))