Influenza HA Vaccine
Application Form/Interview Sheet

For voluntary vaccination

You cannot use this interview sheet for periodic vaccinations.
Please use another sheet distributed by the local government.

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KITASATO DAIICHI SANKYO VACCINE CO., LTD.

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Before receiving a vaccination for influenza HA

1. Influenza and complications

Influenza viruses, suspended in the air or attached to the hands by coughing or sneezing by patients, infect the airway. After one to five days of infection, symptoms develop of fatigue, rapid onset of fever, sore throat, coughing, or sneezing, and the symptoms commonly disappear within about a week. However, if elderly people, babies, immune-compromised people, or adults in weak physical condition are infected, please pay attention because the course of the infection may be serious(such as pneumonia or death).

2. Effects and side effects of the vaccine

The effects of the vaccine have been controversial, but vaccinations reduce the severity of symptoms if you contract the influenza virus and may prevent hospitalization, which might otherwise occur without the vaccination. Side effects of the vaccination include fever, redness and swelling, or induration around the injection site. The frequency of fever is several in 100 people and redness and other symptoms occur in about one in 10 people. The following side effects are rare, but may occur:
(1)shock or anaphylactoid symptoms(such as hives, dyspnea, and angioedema), (2)acute disseminated encephalomyelitis (fever, headache, convulsions, movement disorder, disturbance of consciousness, and other symptoms within several days to two weeks after the vaccination), (3)Guillain-Barre syndrome(such as numbness in limbs and gait disturbance), (4)convulsions (including febrile convulsions), (5)hepatic dysfunction and jaundice, (6)asthma attacks, (7)thrombocytopenic purpura and thrombocytopenia, (8)vasculitis(such as allergic purpura, allergic granulomatous angiitis, and leukocytoclastic vasculitis), (9)interstitial pneumonia, (10)encephalitis or encephalopathy and myelitis, and (11)mucocutaneous ocular syndrome(Stevens-Johnson syndrome).

3. Avoid the vaccination if you have the following conditions:

1)Clearly have a fever(usually over 37.5°C)
2)Sever acute disease
3)A history of anaphylaxis(severe allergic reactions including dyspnea or systemic severe hives within 30 minutes after a vaccination) from the ingredients of this vaccine
4)Any other condition for which your doctor recommends not receiving vaccines

4. Please talk to the doctor before the vaccination if you have the following conditions:

1)Underlying cardiovascular, renal, liver, or blood disease
2)A history of rash or abnormalities from medications or diet(such as chicken eggs or meat)
3)A history of convulsions(spasms) in the past
4)A history of symptoms of suspected allergies, such as fever, systemic rash, and hives within two days after an influenza vaccination in the past
5)A history of abnormalities of the immune system in the past or a family history of congenital immunodeficiency syndrome
6)Bronchial asthma
7)Pregnant
8)Premature birth and delayed development(If the person to be vaccinated is a child)
9)Delayed development and supervised by doctors or public health nurses (If the person to be vaccinated is a child)

5. Please pay attention to the following points after the vaccination:

1)Prepare to meet with the physician in the event of any allergic reactions(such as difficulty breathing, urticaria, or coughing) within 30 minutes after the vaccination.
2)Most side effects(such as fever, headache, and convulsions) are known to occur within 24 hours. Please pay attention to your physical condition at least for one day after the vaccination. If any abnormalities such as high fever or convulsions occur, please seek immediate medical attention from a physician.
3)Redness or pain may occur at the injection site after the vaccination, but it will usually disappear within four to five days. If you experience any changes in your physical condition, please a physician immediately.
4)There is no problem in taking a bath after the vaccination, but do not rub the injection site.
5)Please go on with your daily activities on the day of the vaccination. However, keep the injection site clean after the vaccination and avoid strenuous activity or heavy alcohol use on the day of the vaccination.

Please complete the Interview Sheet for Influenza HA Vaccine(back page) before seeing a physician. If you experience any changes from the usual condition, please talk to a physician.
In the event of any health hazards caused by this vaccine, it may be possible to be reimbursed for any medical costs and receive other support from the Relief System for Sufferers of Adverse Drug Reactions. You can see the details on the website of the Pharmaceuticals and Medical Devices Agency and other resources.

Expected date of vaccination	On , Please come around :	**Name of medical institution**	

Supervised by Tetsuo Nakayama, a professor of Laboratory of Viral Infection in Kitasato Institute for Life Sciences, Kitasato University

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Body temperature before vaccination	_____.___℃

Address	Zip Code		TEL ( ) -
Name of the person to be vaccinated		M・F	Date of birth: / / (day/month/year) (years months)
(Name of guardian)			

Questionnaires	Answers		For doctor use only
Did you read the explanation about the influenza vaccine you will receive today and understand its effects, side effects, and other things?	YES	NO	
Do you have any disease now or do you feel sick today? Disease name, or in what way do you feel sick? ( ) Did you have a fever or any disease within the past month? Do you receive any treatment (such as medication)? Did your doctor tell that you could receive the vaccination today?	YES YES YES YES	NO NO NO NO	
Do you have any history of a special disease (congenital disorder; a disease of the heart, kidney, or liver; immune deficiency disease; blood disease; or other disease)? Disease name ( )	YES	NO	
Do you have any history of skin rashes or hives, or a physical disorder caused by drugs or foods (especially chicken eggs, meat, or other foods derived from chickens)? Name of drug or food ( )	YES	NO	
Have you ever received a vaccination for influenza? (Ⅰ) Last received around ((year) / (month)) (Ⅱ) Have you ever felt sick during or after the vaccination? (Ⅲ) Have you ever felt sick during or after a vaccination except for influenza? Name of vaccine ( )	YES YES YES	NO NO NO	
Have you received a vaccination, other than influenza, within the past four weeks? Name of vaccine ( )	YES	NO	
Do you have a history of convulsions (spasms)?	YES	NO	
Have you ever been diagnosed with a respiratory disease such as interstitial pneumonia or bronchial asthma?	YES	NO	
Do you have a family history of congenital immunodeficiency syndrome?	YES	NO	
Has a family member ever felt sick after a vaccination?	YES	NO	
Has a family member or close friend ever had measles, bastard measles, varicella, or mumps? Disease name ( )	YES	NO	
(For women only) Are you pregnant?	YES	NO	
(If the person to be vaccinated is a child) We ask the developmental history of the child. Birth weight ( ) g Did the child have any abnormality during delivery? Did the child have any abnormality after delivery? Have you ever been told of an abnormality in a physical examination of the infant?	 YES YES YES	 NO NO NO	
Do you have any questions about today's vaccination?	YES	NO	

For doctor use only

I determined that the vaccination (is possible to administer / should be canceled) today as a result of the above medical interview and exam. I explained to the person to be vaccinated (the guardian if the person to be vaccinated is a minor) the effects and side effects of the vaccination based on the Act on Pharmaceuticals and Medical Devices Agency.

Signature or print name and seal _____

Please fill in the blank.
〔If the person to be vaccinated is a minor (except for a married person), the guardian should fill in the blank.〕

I understand the effects, objectives, and the possibility of side effects of the vaccination based on the exam and explanation from the doctor and agree to receive the vaccine.

Signature _____ (If you sign for this person: Relationship _____)
(If the person to be vaccinated cannot sign, please sign for the person and state your relationship to the person.)

Name of vaccine to be used	Indication	Vaccination site/Doctor name/Date of vaccination
Name: Influenza HA vaccine Manufactured by Kitasato Daiichi Sankyo Vaccine Co., Ltd. Lot No.: _____	Subcutaneous injection _____ mL The number of injection _____	Name of medical institution: _____ Doctor name: _____ Date of vaccination: _____ / / , :

All personal information will be used for the medical interview relating to vaccination only.