Kuraoka Clinic

COVID-19 Vaccine Questionnaire & Consent Form

Please Print Information for Person Receiving Vaccine				
Last Name	First Name	DOB (mm/dd/yyyy)	Age	Gender M・F
Street Address		State	Zip	
E-Mail Address		Phone Number		

Medical Insurance	Member ID #	Group ID#	Policy Holder Name	Policy Holder DOB

For adult patients as well as parents of children to be vaccinated: The following questions will help us determine if there is any reason, we should not give you or your child an inactivated Injectable covid vaccination today. If you answer "yes" to any of the questions, it does not necessarily mean you (or your child) should not be vaccinated, but further questioning may be necessary. If a question is not clear, please ask your health care provider.

予防接種を受けられるご本人・お子様の親権者の方へ：コロナ予防接種をご希望の方の中で、本日予防接種が可能かどうかを見極めるために次の質問に答えてください。もし、質問への答えが「はい」であったとしても予防接種が受けられないとは限りません。その場合は、後ほどスタッフより、もう少し細かい質問をさせて頂きます。もし質問の意味がわからないようでしたらスタッフにお尋ねください。

※接種されるお子様の質問表を代理で書かれる場合、以下の質問は接種されるお子様の状態をお答えください。

	COVID-19 Vaccine Screening Questions	YES	NO
1	Have you received a COVID-19 vaccine within the last 2 months? If yes, date vaccine received: ２ヶ月以内にコロナワクチンを接種しましたか？ 接種した場合： 月 日	☐	☐
2	Are you feeling sick today? 本日お熱等、何か病気の症状がありますか?	☐	☐
3	Have you tested positive for Covid-19 within the last 3 months? ３ヶ月以内にコロナにかかりましたか？	☐	☐
4	Have you ever had a serious reaction to the covid vaccine in the past? 過去にコロナワクチンの接種で重大な反応がありましたか？	☐	☐
5	Have you ever had a severe allergic reaction? (e.g.anaphylaxis) For example, a reaction for which you were treated with Epinephrine or an Epipen? 薬や食品などで、エピペンを使わなければいけないほどの重いアレルギー症状を起こしたことがありますか？	☐	☐
6	Have you received another vaccine in the last 14 days? ２週間以内に予防接種を受けましたか？	☐	☐
7	Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? コロナの治療で、受動免疫療法（モノクローナル抗体治療や回復期血漿治療）を受けたことがありますか？	☐	☐
8	Do you have a weakened immune system caused by something such as HIV infection or cancer of do you take immunosuppressive drugs or therapies? HIV やがんなどの免疫不全疾患を持っていますか？免疫抑制薬の服用や免疫抑制治療を受けていますか？	☐	☐

I have been given a copy and have read the Emergency Use Authorization (EUA) and reviewed the FDA Fact Sheet for Recipients and Caregivers (https://www.modernatx.com/covid19vaccine-eua/eua-fact-sheet-recipients.pdf) prior to receiving the COVID-19 vaccine. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine indicated and ask that it be given to me or the person named for whom I am authorized to make this request. My signature acknowledges that I was advised to remain on site for 15 minutes after receiving the vaccine. Those with previous anaphylactic reactions should stay for 30 minutes.

ワクチン接種の前に EUA と FDA の Fact Sheet を読み、接種の効果・副反応などを理解した上で、接種を希望します。
接種後は経過観察のため、当院で 15 分待機してください。過去にアナフィラキシーを含む重いアレルギー症状を起こしたことがある方は、30 分お待ちください。

Patient name (患者様名): 男 ・ 女 DOB (生年月日):
＊ローマ字

Signature (署名) ： Date (日付)
※未成年者の方はご両親のサイン

Vaccine Administration Information/ Kuraoka Clinic use only

Vaccine/Manufacture/ Lot# / Exp.	Dose	Route	Site	Administered By
MODERNA/MODERNA, INC LOT # AU5554B EXP: 6/6/2024	0.25ml	Intramuscular	L R Deltoid	
SPIKEVAX/MODERNA, INC LOT # 3031417 EXP: 4/12/2024	0.50ml		Thigh	

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