Influenza Vaccination Questionnaire(3year old and over:0.5ml)

Name:

Date of Birth:

Body temperature:

Q1....Have you or a member of your family contracted an illness such as Chickenpox,Measles or the new Coronavirus with in the past month?

Yes(Disease name:) Do not have

Q2....Have you ever been told than you have allergies?

Yes(Type:) Do not have

Q3...Have you ever had a seizure?

Yes Do not have

Q4... Have you ever felt sick after getting a Vaccination?

Yes Do not have

Q5... Are you currently using oral medication?

Yes(Name of medicine:) Do not have

Q6...Today`s symptoms are do you have?

Yes(cough / snot / diarrhea / rash / bad mood) Do not have

Q7...Do you have a medicine notebook?

Yes Do not have

< First time receiving influenza vaccine >

Is there any problem with eating eggs ?

Yes Do not have