Intranasal Live Attenuated Influenza Vaccine Pre-examination Form

	<<Body Temperature>>
<< Name >>	<< Date of Birth >> / /

Contracted any illnesses(Such as Mumps, Chickenpox , Measles , or Covid-19) with the past month?	No Yes, (Disease：) Date of illness：(／ ／)
Have you ever been diagnosed with a respiratory illness such as severe asthma ?	No Yes, (Type：)
Have you ever had a skin rash or felt unwell after taking medicine or eating foods(such as gelatin , eggs or chicken meat)?	No Yes, (Type：)
Have you ever had a seizure?	No Yes,
Have you ever felt unwell after Vaccination?	No Yes,
Are you currently taking any oral medications?	No Yes(Name of medicine:)
Are you experiencing any of the following symptoms today?	No Yes (cough / runny nose / diarrhea / rash / irritability)
Are there any other health concerns you would like to share with doctor or questions about today's Vaccination?	No Yes (specify:)

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