Consent Form for Clinical Services at the Travel Clinic

To the Hospital Director, National Center for Global Health and Medicine,
Japan Institute for Health Security

I have reviewed the information materials for the items below and received explanations from the physician (Name: _____). I understand the information and consent to the indicated care. My consent is voluntary and may be changed or withdrawn before the care is provided. If I decline or withdraw consent, the relevant vaccination or other procedure will not be performed, but this will not adversely affect my other medical care.

Please check the items that have been explained to you.

☐ **Vaccination**

Indications and effectiveness; methods of administration, including simultaneous vaccination; intervals and future schedule; possible adverse reactions and their management; compensation for vaccine-related injury; fees and related matters.

Information sheet: *Travelers' Vaccines: Before Vaccination.*

Please circle the vaccine(s) to be given:

Hepatitis A; Hepatitis B; Tetanus; Rabies; Japanese encephalitis; Typhoid fever; Measles; Rubella; Mumps; Varicella; MR (measles/rubella); Shingles; IPV (inactivated polio); DPT (diphtheria/pertussis/tetanus); DPT-IPV-Hib (5-in-1); Quadrivalent meningococcal (ACWY); Pneumococcal (23-valent); Pneumococcal (20-valent); Pneumococcal (21-valent); HPV (9-valent); BCG; Rotavirus; RSV; Tick-borne encephalitis; COVID-19; Inactivated influenza; Intranasal live attenuated influenza; Other (_____)

☐ **Vaccines not approved in Japan**

Indications and effectiveness; methods of administration, including simultaneous vaccination; intervals and future schedule; possible adverse reactions and their management; compensation for vaccine-related injury.

Information sheets: *Travelers' Vaccines: Before Vaccination; other relevant materials.*

Please circle the imported vaccine(s) to be given:

Hepatitis A (Havrix); Rabies (Verorab); Adult Tdap (tetanus/diphtheria/acellular pertussis); MMR (measles/mumps/rubella; Priorix); Meningococcal B (Bexsero); Cholera (Dukoral); Other (_____)

☐ **Off-label vaccination: regimen, dose, or recipient group not specified in the package insert**

Information sheets: *Vaccination in Populations Not Specified in the Package Insert; Information Sheet on the Use of Unapproved New Drugs, etc. (Hib).*

☐ **Oral malaria prophylaxis**

Information sheet: *Pocket Guide to Malaria Prevention.*

☐ **Oral malaria prophylaxis: off-label use in Japan (not covered by health insurance)**

Information sheet: *Doxycycline for Malaria Prophylaxis.*

☐ **Oral prophylaxis for altitude sickness: off-label use in Japan (not covered by health insurance)**

Information sheet: *Medication for the Prevention of Altitude Sickness.*

☑ I confirm that vaccinations are self-pay services charged according to this hospital's Travel Clinic vaccine price list, and that consultation fees, vaccine fees, certificate fees, and other charges apply.

☑ If I cancel care for personal reasons after agreeing on a vaccination or testing plan with the physician, I will be required to pay the fee for the relevant vaccination or test (for example, because a vaccine becomes unusable after opening or preparation).

Date of consent (year / month / day): _____ / _____ / _____

Consenting person (vaccine recipient) Name: _____

Parent/guardian (if the vaccine recipient is under 18 years of age)

Name: _____ Relationship: _____