Please tick in ○ and fill out properly in □ and on _______ with black or blue ballpoint pen

Start date (dd-mmm-yyyy): □□-□□□-□□□□

Screening	
1) Age of the participant is between 18 to 60 years old	○ Yes ○ No
2) Would the participant be able to write a consent form?	○ Yes ○ No
3) Would the participant be able to attend the visit on day 21 post-vaccination which is on (dd-mmm-yyyy) □□-□□□-□□□□?	○ Yes ○ No
4) Has the participant been diagnosed having influenza infection during the past 6 months?	○ Yes ○ No ○ Not certain
5) Has the participant had fever together with headaches, muscle aches, cough, sore throat, runny nose, headaches or fatigue during past 6 months?	○ Yes ○ No ○ Not certain
6) Has the participant receipt vaccination against during the past 6 months?	○ Yes ○ No ○ Not certain
7) Does the participant have a plan to receive any vaccination in the next 3 weeks?	○ Yes ○ No
8) Participant's body temperature	□□.□ °C
9) Has the participant been diagnosed having one of these diseases? (can select more than one)	○ HIV/AIDs ○ Cancer ○ Autoimmune disease
10) Is the participant currently using immunosuppressant drug, on radiotherapy or on chemotherapy?	○ Yes ○ No

11) 11.1 Has the participant used immunosuppressant drug before? 11.2 If yes, when was the last dose taken?	◯ Yes ◯ No ◯ Not certain Please specify ____________________
12) Does the participant have any chronic illness? If yes, what is that illness?	◯ Yes ◯ No ◯ Heart disease ◯ Diabetes ◯ High blood pressure ◯ Other, please specify ______________ ________________________________
13) Gender	◯ Female ◯ Male
For female participant only • Result from the pregnancy test • Is the participant breastfeeding? • Is the participant trying to get pregnant during these 21 days of the trial? • Is the participant willing to take reliable birth control measures for 1 month after get the vaccination?	◯ Pregnant ◯ Not pregnant ◯ Not done ◯ Yes ◯ No ◯ Yes ◯ No ◯ Yes ◯ No

For investigator in screening step only:
Is the participant eligible for enrolling in the trial? ○ Yes ○ No If yes, given subject ID: □□□
Investigator's name: ______________________________ Signature ( ) Name □□-□□□-□□□□ Date (dd-mmm-yyyy)

Enrolment

Demographic data	
Birth date	Birth year ☐☐☐☐ Birth month ☐☐☐
Gender	◯ Female ◯ Male
Race	◯ Thai ◯ Hill tribe ◯ Myanmar ◯ Laos ◯ Chinese ◯ Asian Indian ◯ White ◯ Black or African ◯ Other please specify_________________

Vital signs	
Height ☐☐☐ cm	Weight ☐☐☐ kg
Sitting pulse ☐☐☐ beats/minute	Respiration ☐☐ /minute
Sitting blood pressure (systolic/diastolic) ☐☐☐/☐☐☐ mmHg	

Medical history and medication	
Does the participant have any allergy? If yes, What is the allergen(s)? (Categories can be selected more than one)	◯ Yes ◯ No ◯ Medicine, please specify ______________ ___________________________________ ◯ Seafood, prawn, or shellfish ◯ Pollen ◯ Other, please specify ______________ ___________________________________ ◯ Unknown
Does the participant take medicine often? (every day to every week) If yes, Medicine 1 What is medicine the participant taking often? Dose For curing what illness? Medicine 2 What is medicine the participant taking often?	◯ Yes ◯ No Please specify ______________________ ___________________________________ ___________________________________ Please specify ______________________ ___________________________________ Please specify ______________________ ___________________________________

Dose	________________
For curing what illness?	Please specify ________________
Medicine 3 What is medicine the participant taking often?	Please specify ________________
Dose	________________
For curing what illness?	Please specify ________________

Blood collection	
Staff who collect the blood of the participant	○ Nurse ○ Medical technician ○ Other please specify
Is the volume of the blood collected as the plan?	○ Yes ○ No

Vaccination	
Actual start time	□□:□□ ○ AM ○ PM
What was the anatomical location of the administration?	○ Upper right arm ○ Upper left arm

For investigator in enrolment step only:
Investigator's name: ______________________________ Signature ( ) Name ☐☐-☐☐☐-☐☐☐☐ Date (dd-mmm-yyyy)

CRF for lab results

Blood sample	
Testing date (dd-mmm-yyyy):	☐☐-☐☐☐-☐☐☐☐
Is the volume of the blood sample enough for the test?	◯ Yes ◯ No
Name of the staff who conducts the test	Full name: ____________________
HAI titer result	Please specify ____________________ ____________________
Date of reading the results (dd-mmm-yyyy):	☐☐-☐☐☐-☐☐☐☐
Name of the staff who read the result and write down this form	Full name: ____________________