①Haemophilus inf. Type B(1・2・3・4)	②Pneumococcus (1 · 2 · 3 · 4)	3Hapatitis B (1 · 2 · 3) 4BCG
⑤DPT-IPV (1 · 2 · 3 · 4) ⑥MR (1 · 2	2) ⑦Varicella(1・2) ⑧Japanes	e Encephalitis (1 · 2 · 3 · 4) 9D7
①HPV (1 · 2 · 3) ①Other vaccination ()	

↑ Please circle your choice.

Vaccine Screening Questionnaire

Takarazuka citv

	vaco	The Screening Qu	25 t I	Ullila	116			Takarazuka City
Address			Date	of Birth	/		/	(dd/mm/yyyy)
Phone Number			(ir	A. D.)	Age (year	r(s)	month(s))
Child's Name			Body temperature before					Doctor's comment
		M .						
Parent/Guardian' s Name			F				Degrees	
	·	Questionnaire for Vaccination	1			Ans	swer	
1 Does the child have a resident registration in Takarazuka city now?			Yes	No				
2 Have you read the document explaining the vaccination that will be administered today?			Yes	No				
3 For those who has under 7 years old child								
Please answer the following questions about the child.								
Birth Weight Did the child have any abnormal findings at delivery?					Yes	NO		
() g Did the child have any abnormal findings after birth?				Yes	NO			
		any abnormality identified at an inf	ant heal	th check	?	Yes	NO	
4 Is the child						Yes	No	
If so, desci	ribe the nature of	the illness. ()			
	ld been ill in the	past month?				Yes	No	
Disease name)			
		nd of the child had measles, chickenp	ox or m	umps		.,,		
in the past					,	Yes	No	,
Disease name	-)			
	_	anyone with tuberculosis(including	family	members)?	'	Yes	No	
		in the past month?				Yes	No	ľ
Disease name)				
		al anomaly, heart, kidney, liver, centra		disease,	1mmune	17	N	
		ses for which you have consulted a d	octor?		,	Yes	No	ı S
Disease name			* - 1)	N.T.	37	E
		r who manages the above disease agre	e with	today's va	accination?	No	Yes	F
		spasm or fit)in the past?				Yes	No	H
	at age did it occu)	ļ		·
		preceding question, did the child ha				No	Yes	,
11 Has the child ever had a rash or urtocaria(hives or 'nettle rash') as a reaction to medications or					Yes	No	i i	
food or become ill after eating certain foods or receiving certain medications?							2	
12 Does the child have a family member or relative with a congential immunodeficiency?					Yes	No	H	
13 Has the ch	ild had a serious	reaction to a vaccine in the past?				Yes	No	
Vaccine na	ame ()		105	110	Ç
14 Has any far	mily member or rela	ative of the child had a serious rea	ction to	a vaccii	ne in the past?	Yes	No	-
15 Has the child received a transfusion of blood or blood products or been given a medicine					Yes	No	ı İ	
called gamma globulin(※) in the past 6 months?					165	NO	[
16 Do you have	e any questions ab	out today's vaccination?				Yes	No	
17 For those v	who has a female ch	nild of 13 years old or older				V	Ν-	
Is there a p	possibility that t	he child is pregnant(e.g. her period	is lat	er than e	xpected day)?	Yes	No	,
医師記入欄(Doc	tor's comment)						•	
以上の問診及	及び診察の結果、学	今日の予防接種は (実施できる・見	合わせ	した方が	(良い) と判断			
保護者(本人	、) に対して予防抗	妾種の効果、副反応及び予防接種健	康被害	救済措置	について、説明を	しまし	た。	
Based on the al	bove answers and t	he results of interview, I have deci	ded tha	t the chi	ld (can / should n	ot) rec	eive a v	vaccination today.
•		uardian the information concerning t		fits and	side effects of va	ccinati	on and t	he support
provided to peo	ople who have had	adverse events associated with vacci	nation.					
	<u>E</u>	師署名又は記名押印(Signature or Na	me and	Seal of Do	octor) []
This screening	questionnaire is	used to improve the safety of vaccin	ation.	The child	has been intervie	wed by	the doct	or, and information
concerning the benefits, objectives, and risks(including serious side effects) of vaccination has been explained to me by the doctor,								
as has the nature of support provided if adverse events occur. I believe that I understand this information.								
I (do / do not)* give consent for the child to be vaccinated. *Please circle your choise.								
I understand the above and agree that this questionnaire can be submitted to the municipal office.								
Signature of Parent / Guardian [Vaccine Name Dosage 実施場所 (Institution) /医師名 (Doctor Name) /接種年月日 (Date Administered)								
Vacc Vaccine Name	ine Name	Dosage 実施場所(I 実施場所(Inst			師名 (Doctor Name)	/按種年	-ЛЦ (D	ate Administered)
Lot Number		医師名(Doctor		•				
(注) 有効期限がきれて	ていないか要確認	m l 接種年月日 (Da		nistered)				
		that is injected to prevent infections			nepatitis, and to tr	eat seve	ere infec	tions. Certain