Vaccine Screening Questionnaire for
(DPT-IPV , DPT , DT)

Times 1st 2nd 3rd 4th

該当欄にレ点をつけてください

記入例 レ

※医療機関の方へ

本英語予診票は見本です。
実際の記載は日本語予診票へ

Address	Kumamoto City	Telephone -	
フリガナ			
Child's Name		Birth Date H Year Month Day	
Parent/ Guardian'sName		Age (years months)	Sex Male・Female
Normal Temp.	℃	Body temperature before interview	℃

Questionnaire	Answer		Doctor's comment
Have you read the notice of vaccination from Kumamoto City?	No	Yes	
Please answer the following questions about the child. Birth Weight ( ) g Did the child's Birth Weight have any abnormal findings at delivery? Did the child have any abnormal findings after birth? Was any abnormality identified at an infant health check?	Yes Yes Yes	No No No	
Is the child sick today? If so, describe the nature of the illness. ( )	Yes	No	
Has the child been ill in the past month? Disease name ( )	Yes	No	
Has any family member or friend of the child had measles, rubella, chickenpox or mumps in the past month? Disease name ( )	Yes	No	
Has the child been exposed to anyone with tuberculosis (including family members)?			
Has the child been vaccinated in the past month?Vaccine name ( )	Yes	No	
Does the child have a congenital anomaly, heart, kidney, liver, central nerve disease,immune deficiency, or any other diseases for which you have consulted a doctor?	Yes	No	
Where relevant, did the doctor who manages the above disease agree with today'svaccination?	No	Yes	
Has the child had a seizure (spasm or fit) in the past?If so, at what age did it occur? ( )	Yes	No	
If you answered "yes" to the preceding question, did the child have a fever at thattime?	Yes	No	
Has the child ever had a rash or urticaria (hives or 'nettle rash') as a reaction to medications or food or become ill after eating certain foods or receiving certain medications?	Yes	No	
Does the child have a family member or relative with a congenital immunodeficiency?	Yes	No	
Has the child had a serious reaction to a vaccine in the past? Vaccine name ( )	Yes	No	
Has any family member or relative of the child had a serious reaction to a vaccine in the past?	Yes	No	
Has the child received a transfusion of blood or blood products or been given a medicine called gamma globulin in the past 6 months?	Yes	No	
Do you have any questions about today's vaccination?	Yes	No	

The child has been interviewed by the doctor, 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 choice.

This paper has aimed at securing the safety of the vaccination. Signature of guardian
I agree for this paper to be submitted to Kumamoto City after this is understood.

Doctors Notes	After physical examination,the child is recommended for immunization: (Yes ・ No) I have explained to the parent/guardian the information concerning the benefits and side effects of vaccination and the support provided to people who have had adverse events associated with Signature of Doctor

Name of vaccine used		Place of immunization ; Name of doctor
The name of vaccine Lot.No Expiration date H Y M D	Subcutaneous injection	Date of immunization H Y M D Code of Hospital 4 3 Name of Hospital 本英語予診票は見本です。 Name of Doctor 実際の記載は日本語予診票へ
Only Examination(Reason)		

Gamma globulin is a blood product that is injected to prevent infections, such as type A hepatitis, and to treat severe infections. Certain vaccines(for example, measles vaccine) are occasionally less effective in people who have received this product in