①Haemophilus inf. Type B（１・２・３・４） ②Pneumococcus（１・２・３・４） ③Hapatitis B（１・２・３） ④BCG
⑤DPT-IPV-Hib（１・２・３・４） ⑥MR（１・２） ⑦Varicella（１・２） ⑧Japanese Encephalitis（１・２・３・４） ⑨DT
⑩HPV（１・２・３） ⑪Rotavirus:Rotarix(１・２)/ RotaTeq(１・２・３） ⑫Other vaccination（ ）

↑Please circle your choice.

Vaccine Screening Questionnaire

Takarazuka city

Address		Date of Birth (in A.D.)	/　/　(dd/mm/yyyy)
Phone Number			Age(　year(s)　month(s))
Child's Name		M・F	Body temperature before interview: Degrees
Parent/Guardian's Name			Doctor's comment

Questionnaire for Vaccination	Answer		
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 ( ) g　Did the child have any abnormal findings at delivery?	Yes	NO	
Did the child have any abnormal findings after birth?	Yes	NO	
Was any abnormality identified at an infant health check?	Yes	NO	
4 Is the child sick today? If so, describe the nature of the illness. ( )	Yes	No	
5 Has the child been ill in the past month? Disease name ( )	Yes	No	
6 Has any family member or friend of the child had measles,chickenpox or mumps in the past month? Disease name ( )	Yes	No	
7 Has the child been exposed to anyone with tuberculosis(including family members)?	Yes	No	
8 Has the child been vaccinated in the past month? Disease name ( )	Yes	No	
9 Does the child have a congenial anomaly,heart,kidney,liver,central nerve disease,immune deficiency,or any other diseases for which you have consulted a doctor? Disease name ( )	Yes	No	
Where relevant, did the doctor who manages the above disease agree with today's vaccination?	No	Yes	
10 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 that time?	No	Yes	
11 Has the child ever had a rash or urtocaria(hives or 'nettle rash')as a reaction to medications or food or become ill after eating certain foods or receiving certain medications?	Yes	No	
12 Does the child have a family member or relative with a congential immunodeficiency?	Yes	No	
13 Has the child had a serious reaction to a vaccine in the past? Vaccine name ( )	Yes	No	
14 Has any family member or relative of the child had a serious reaction to a vaccine in the past?	Yes	No	
15 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	
16 Do you have any questions about today's vaccination?	Yes	No	
17 ***For those who has a female child of 13 years old or older*** Is there a possibility that the child is pregnant(e.g. her period is later than expected day)?	Yes	No	

※Please fill out this form with a black ballpoint pen.

医師記入欄（*Doctor's comment*）

以上の問診及び診察の結果、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）に対して予防接種の効果、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 above answers and the results of interview, I have decided that the child **(*can / should not*)** receive a vaccination today.
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 vaccination.

医師署名又は記名押印（*Signature or Name and Seal of Doctor*）〔　〕

This screening questionnaire is used to improve the safety of vaccination. 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 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）
Vaccine Name		実施場所（Institution）
Lot Number		医師名（Doctor Name）
（注）有効期限がきれていないか要確認	ｍｌ	接種年月日（Date Administered）

※Gamma globulin is a blood product that is injected to prevent infections, such as type A hepatitis, and to treat severe infections. Certain vaccination(for example, measles vaccine) are occasionally less effective in people who have received this product in the preceding 3 to 6 months.

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