Vaccination Register
and
Screening Questionnaire for DPT-IPV-Hib
（Combination of Diphtheria・Pertussis・Tetanus・Inactive Polio・Hib vaccine）

Chiyoda city

	（Age: years and months as of the date of vaccination）	
	Expiration date	
	Parent/Guardian's Name	
	Phone no.	

Today's vaccination and vaccination history ※Please mark "○" for today's vaccination.	First time of the Initial vaccination : First	First time of the Initial vaccination : Second	First time of the Initial vaccination : Third	Additional for the initial vaccination
	Year Month Day	Year Month Day	Year Month Day	

Please fill in the necessary items for the questions in the broad lined box and mark "○" on an applicable answer in the answer box.

Body temperature before interview	Degrees C

List of Questions		Answer		Doctor's Comment
1 Have you read the directions from Chiyoda City about today's vaccination?		No	Yes	
2 We'd like to ask you about your child's developmental history.				
Birth weight( )g	Did the child have any abnormality at delivery?	Yes	No	
	Did the child have any abnormality after birth?	Yes	No	
Have you ever told that your child had some abnormality at the child's health checkup?		Yes	No	
3 Is the child sick today? Please write the specific symptoms. ( )		Yes	No	
4 Has the child been ill in the past month? Name of illness ( )		Yes	No	
5 Has any family member or friend of the child had illness such as measles, rubella, chickenpox or mumps in the past month? Name of illness ( )		Yes	No	
6 Has the child been vaccinated in the past month? Name of vaccination (Date of vaccination /)		Yes	No	
7 Has your child ever had a special disease such as congenital abnormality, or heart, kidney, lever, cerebral nerve disease, immune deficiency or any other disease for which you have consulted a doctor? Name of the illness ( )		Yes	No	
Did the doctor who manages the above disease give a permission to take today's vaccination?		Yes	No	
8 Is the child taking a special medicine such as steroid (internal use) and immunosuppressant now?		Yes	No	
9 Has the child had a seizure (spasm or fit) in the past? Around ( ) years old		Yes	No	
Did the child have a fever at that time?		Yes	No	
10 Has the child ever had an anathema or hives, or become ill because of the medication or food?		Yes	No	
11 Does the child have a family member or relative with a congenital immunodeficiency?		Yes	No	
12 Has the child ever become ill after the vaccination? Name of vaccination ( )		Yes	No	
13 Has any family member or relative of the child had a serious reaction to a vaccine in the past?		Yes	No	
14 Do you have any questions about today's vaccination?		Yes	No	

医師記入欄

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 ・ 見合わせたほうがよい ） と判断します。
保護者に対して、予防接種の効果、副反応及び予防接種健康被害救済制度について、説明をしました。

医師署名又は記名押印

Entry column for the guardian

Having doctor's checkup, hearing explanation, and understanding the object, effect and critical side effects of vaccination, and the Relief System for Health Damage by Vaccination, I give a consent to take vaccination.

（ Agree ・ Not agree ）
※Please circle either one in the parenthesis

The purpose of this medical questionnaire is to ensure the safety of vaccination. Understanding the purpose, I agree with submitting this questionnaire to the City.

Signature of the guardian or escort

使用ワクチン	実施場所・接種医師名
□ゴービック □ クイントバック Lot No. (注)有効期限が切れていないか要確認	実施機関名・住所・電話番号
接種量 0.5ml	
接種方法	
皮下・筋肉内	接種医師名
接種部位	
左・右 上腕 / 大腿	接種(予診)年月日 年 月 日