

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 "O" for today's vaccination.	First time			Second time			Third time
	Year	Month	Day	Year	Month	Day	

Body temperature before interview	Body temperature after interview
97.8	97.6
97.9	97.7
98.0	97.8
98.1	97.9
98.2	98.0
98.3	98.1
98.4	98.2
98.5	98.3
98.6	98.4
98.7	98.5
98.8	98.6
98.9	98.7
99.0	98.8
99.1	98.9
99.2	99.0
99.3	99.1
99.4	99.2
99.5	99.3
99.6	99.4
99.7	99.5
99.8	99.6
99.9	99.7
100.0	99.8
100.1	99.9
100.2	100.0
100.3	100.1
100.4	100.2
100.5	100.3
100.6	100.4
100.7	100.5
100.8	100.6
100.9	100.7
101.0	100.8
101.1	100.9
101.2	101.0
101.3	101.1
101.4	101.2
101.5	101.3
101.6	101.4
101.7	101.5
101.8	101.6
101.9	101.7
102.0	101.8
102.1	101.9
102.2	102.0
102.3	102.1
102.4	102.2
102.5	102.3
102.6	102.4
102.7	102.5
102.8	102.6
102.9	102.7
103.0	102.8
103.1	102.9
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103.6	103.4
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103.9	103.7
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104.1	103.9
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113.3	113.1
113.4	113.2
113.5	113.3
113.6	113.4
113.7	113.5
113.8	113.6
113.9	113.7
114.0	113.8
114.1	113.9

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	Was the child who will take vaccination born from the mother who is positive about Hepatitis B virus, HBs antigen?	Yes ※	No	
※If Yes, the child is not eligible for routine vaccination.				
3	We'd like to ask you about your child's developmental history. Birth weight()g	Did the child have any abnormality at delivery? Did the child have any abnormality after birth?	Yes Yes	No No
	Have you ever told that your child had some abnormality at the child's health checkup?	Yes	No	
4	Is the child sick today? Please write the specific symptoms. ()	Yes	No	
5	Has the child been ill in the past month? Name of illness ()	Yes	No	
6	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	
7	Has the child been vaccinated in the past month? Name of vaccination (Date of vaccination /)	Yes	No	
8	Has your child ever had a special disease such as congenital abnormality, or heart, kidney, liver, cerebral nerve disease, immune deficiency or any other disease for which you have consulted a doctor? Name of the illness () Did the doctor who manages the above disease give a permission to take today's vaccination?	Yes Yes	No No	
9	Is the child taking a special medicine such as steroid (internal use) and immunosuppressant now?	Yes	No	
10	Has the child had a seizure (spasm or fit) in the past? Around () years old Did the child have a fever at that time?	Yes Yes	No No	
11	Has the child ever had an anathema or hives, or become ill because of the medication, food or natural rubber "latex" products?	Yes	No	
12	Does the child have a family member or relative with a congenital immunodeficiency?	Yes	No	
13	Has the child ever become ill after the vaccination? Name of vaccination ()	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	Do you have any questions about today's vaccination?	Yes	No	

醫師記入欄

2※に該当する場合、母子感染予防に係る保険診療のため、定期予防接種の対象外であることを説明しました。

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。

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。

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 (注)どのワクチンでも 接種量は0.25ml ☐ビームケン 0.25ml ☐ビームケン 0.5ml ☐ヘプタバックス-Ⅱ バイアル0.5ml ☐ヘプタバックス-Ⅱ シリンジ0.25ml Lot No. (注)有効期限が切れていないか要確認	実施場所・接種医師名		
	実施機関名・住所・電話番号			
	接種部位			
	左・右	上腕 大腿	接種(予診)年月日	