

Vaccination Register and Screening Questionnaire for MR

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.	Initial	Secondary		
	Date of the first MR vaccination	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.

List of Questions	Body temperature before interview	Degrees C	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, liver, 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 Has the child received a transfusion of blood or given a gamma globulin in the past 6 months? ※	Yes	No	
15 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 Lot No. (注)有効期限が切れていないか要確認 接種量 0. 5ml 接種部位(皮下) 左・右 上 腕 大 腿	実施場所・接種医師名 実施機関名・住所・電話番号 接種医師名 接種(予診)年月日 年 月 日
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※(Note) Gamma globulin is a blood product that may be injected to prevent infections such as type A hepatitis, and to treat severe infections.
Certain active vaccines are occasionally less effective in people who have received this product in the preceding 3 to 6 months.