## MR(麻しん・風しん混合) vaccine: Vaccination Register and Screening Questionnaire

					<u> </u>			
Address								
Date of birth (yyyy/mm/dd) Patient's name					Date of birth			
Age						( years months)		
Parent/guardian name Sex						M · F		
接種期限								
Phone								
1 TOTO								
Please fill in the question items in the bold box below and circle one of the answer columns.  Body temperature before interv						view		°C
Questionnaire for Vaccination						Answer		Doctor's
Quodiomano for vaccination								comment
Have you read the document (sent to you previously from your city) about the vaccination that will be administered today?							Yes	
Please answer about your child's development history.								
Birth weight ( ) gram Did the child have abnormal findings at delivery?							No	
Did the child have any abnormal findings after birth?						Yes	No	
Have you ever been told any abnormal findings at an infant health check?						Yes	No	
3. Is the child sick today?						Yes	No	
If so, describe the specific symptoms. (								
4. Did the child have a disease within the last one month? Name of disease (						Yes	No	
5. Has any family member or friend of the child had disease such as measles, rubella, chickenpox or mumps within one month?						Yes	No	
Name of disease: (								
6. Has the child been vaccinated in the past month?						Yes	No	
Name of vaccination ( Date of vaccination; / )								
7. Does the child have a congenital anomaly, heart, kidney, liver, central nerve disease, immune deficiency, or any other diseases for which you						Yes	No	
have consulted a doctor? Name of disease (								
Has the doctor treating disease told you that the child could have the vaccination today?						Yes	No	
8. Are you currently taking any special medication, such as steroids or immunosuppressants						Yes	No	
9. Has the child had a seizure (spasm or fit) in the past? If Yes: age ( ) years old.						Yes	No	
Did the child have a fever at that time?						Yes	No	
10. Has the child ever had a rash or hives or become ill because of the medications 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?						Yes	No	
13. Has any family member or relative of the child had a serious reaction to a vaccination in the past?						Yes	No	
14. Have you received blood transfusions or gamma globulin within 6 months? *								
15. Do you have any question about the 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。								
体験者に対して、『MD技権の効果、助及心及び『MD技権性保険者が指向技について、配列をひよりた。 医師署名又は記名押印								
Entry column for parent/guardian:			使用ワクチン実施場所・接種医師名					
I have been interviewed and explained by the doctor. I have understood			Lot No.	主所・電話番号				
the benefit, objectives, and risk of serious side effects, and also the Relief								
System for Health Damage by Vaccination. Now, I confirm my intent on 東京都北区豊島 5-5-5-107								
taking vaccination as follows.					」ま町クリニック € 03-3027-3778			
( Agree · Not agree ) 接種量 電話 03-3927-3778  This screening questionnaire is used to improve the safety of vaccination.								
I understand the above and agree that this questionnaire can be 接種部位(皮下)								
submitted to the City. 接種医師名								
Signature of Parent/Guardian or Companion			左 上 腕 - ・ 大 腿	接種(予診)	年月日	年	月	В
	and product that is injected to provent infections		4		ations Cartain vaccines (			

<sup>\*</sup> Gamma globulin is a blood product that is injected to prevent infections, such as type A hepatitis, and to treat severe infections. Certain vaccines (live attenuated vaccine; for example measles vaccine) are occasionally less effective in people who have received this product in the preceding 3 to 6 months.