DPT-IPV（４種混合） vaccine: Vaccination Register and Screening Questionnaire

Address	北区		
Patient's name		M・F	Date of birth: Age: years months
Parent/guardian name		Phone	

Vaccination history (yyyy/mm/dd)	First time vaccination	Second time vaccination	Third time vaccination	Booster vaccination
	(/ /)	(/ /)	(/ /)	

Please fill in the question items in the bold box below and circle one of the answer columns.

Body temperature before interview	°C

Questionnaire for Vaccination	Answer		Doctor's comment
1. Have you read the document (sent to you previously from your city) about the vaccination that will be administered today?	No	Yes	
2. Please answer about your child's development history.			
Birth weight ( ) gram — Did the child have abnormal findings at delivery?	Yes	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? If so, describe the specific symptoms. ( )	Yes	No	
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? Name of disease: ( )	Yes	No	
6. Has the child been vaccinated in the past month? Name of vaccination (Date of vaccination; /)	Yes	No	
7. Does the child have a congenital anomaly, heart, kidney, liver, central nerve disease, immune deficiency, or any other diseases for which you have consulted a doctor? Name of disease ( ) Has the doctor treating disease told you that the child could have the vaccination today?	Yes Yes	No 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. Did the child have a fever at that time?	Yes Yes	No 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. 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。

医師署名又は記名押印

Entry column for parent/guardian:

I have been interviewed and explained by the doctor. I have understood 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 taking vaccination as follows.

(Agree ・ Not agree)

This screening questionnaire is used to improve the safety of vaccination. I understand the above and agree that this questionnaire can be submitted to the City.

Signature of Parent/Guardian or Companion

使用ワクチン	実施場所・接種医師名
□クアトロバック □テトラビック □スクエアキッズ 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 〒114-0003 東京都北区豊島 5-5-5-107 としま町クリニック 電話 03-3927-3778
接種量 0.5 mL	
接種部位（皮下） 左・右　上腕　大腿	接種医師名
	接種（予診）年月日　年　月　日