# Vaccination Register
# and
# Vaccine Screening Questionnaire for BCG

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 Adachi City about 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 somebody around the child such as family member ever been diagnosed with tuberculosis? | 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, 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 | |
| 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 | Yes | No | |
| Did the child have a fever at that time? | Yes | No | |
| 11 Has the child ever had an anthema or hives, or become ill because of the medication or food? | 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 | |

**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 |
|---|---|---|
| Lot No.<br>(注)有効期限が切れていないか要確認 | | 実施場所 |
| 接種量<br>0．1ml | | 接種医師名 |
| 接種部位(皮下) | | |
| 左・右 | 上 腕<br>その他( ) | |
| | | 接種(予診)年月日 年 月 日 |