Rotavirus Vaccine
Vaccination Register and Screening Questionnaire

Vaccination history －Mark✔on the box ☐ Circle either type of vaccine you took. Fill in the date of previous vaccination	☐ First time vaccination (Rotarix RV1・RotaTeq RV5)	☐ Second time vaccination (Rotarix RV1・RotaTeq RV5)	☐ Third time vaccination (RotaTeq RV5)
	Year Month Day	Year Month Day	

※If this is the first time, make sure that today is not past 14 weeks and 6 days after birth.

※If you are unsure of the vaccines you have received so far, show your doctor the record of vaccination in the maternal and child health handbook or vaccination record sheet, or check with the medical institution that you vaccinated last time.

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

Body temperature before interview	℃

Questionnaire for Vaccination	Answer		Doctor's comment
1 Have you read the directions sent to you by Adachi City about vaccination that will be administered today?	No	Yes	
2 Did you understand the effects and side reactions of vaccination today?	No	Yes	
3 Were you explained about an intussusception and understand it?	No	Yes	
4 Please answer about your child's development history			
Birth weight（ ）g — Did the child have any 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	
5 Is the child sick today?	Yes	No	
If so, describe the specific symptoms.（ ）	Yes	No	
6 Did the child have a disease within the last one mon Name of disease（ ）	Yes	No	
7 Has any family member or friend of the child had disease such as measles, rubella,chickenpox or mumps wit	Yes	No	
one month? Name of disease （ ）	Yes	No	
8 Has the child been vaccinated in the past month?	Yes	No	
Name of vaccination（ Date of vaccination / ）	Yes	No	
9 Has the child had an intussusception in the past? ※If Yes, the child cannot take vaccinati	Yes	No	
10 Are there congenital gastrointestinal disorders that have not been treated ? ※If Yes, the child cannot take vaccinati	Yes	No	
11 Has the child ever been diagnosed with an immune deficiency,had infectious diseases such as pneumonia	Yes	No	
or otitis media, had repeated diarrhea, or had a poor weight gain?	Yes	No	
12 Does the child have a congenital anomaly,heart,kidney,liver,central nerve disease,immune deficiency,or any	Yes	No	
diseases for which you have consulted a doctor? Name of disease（ ）	Yes	No	
Has the doctor treating disease told you that the child could have the vaccination today?	Yes	No	
13 Has the child had a seizure (spasm or fit) in the past? Around ( ) months old	Yes	No	
Did the child have a fever at that time ?	Yes	No	
14 Has the child ever had a rash or hives or become ill because of medications or food?	Yes	No	
15 Does the child have a family member or relative with a congenital immunodeficiency?	Yes	No	
16 Has the child ever become ill after the vaccination?	Yes	No	
Name of vaccination （ ）	Yes	No	
17 Has any family member or relative of the child had a serious reaction to a vaccination in the past?	Yes	No	
18 Did the mother receive any immunosuppressive medicines during her pregnancy? Name of medicine ）	Yes	No	
19 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(特に腸重積症)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 benefits,objectives,and a risk of serious side effects(especially an intussusception), and also the Relief System for Health Damage by Vaccination. Now, I confirm my intent on taking vaccination as follows.

（ Agree ・ Not agree ）
※Please circle your choice

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
該当に☑してください ☐ ロタリックス(1価) 1.5mL ☐ ロタテック(5価) 2mL Lot No.	実施機関名・住所・電話番号
(注)有効期限が切れていないか要確認	接種医師名
経口接種	接種(予診)年月日 (西暦) 年 月 日