Vaccination Register
and
Screening Questionnaire for Cervical Cancer
（Human Papilloma Virus Infection）

Today's vaccination and vaccination history ※Please mark "○" for today's vaccination.	First (Cervarix・Gardasil) Year Month Day	Second (Cervarix・Gardasil) Year Month Day	Third

※ If you do not know about the vaccination the child has taken, please show the vaccination record of Boshi Techo or vaccination record slip to the doctor, or inquire the medical institute conducted vaccination last time.

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 today's vaccination?	No	Yes	
2 We'd like to ask you about your child's developmental history. Birth weight ( )g Was the child pointed to be a lighter-built at the birth, or to have abnormality at the checkup of birth, after birth, or infant?	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, 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	
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 anthema 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 Do you have possibility of pregnancy（late period etc.）?	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。

保護者または接種を受ける本人に対して、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 (own writing).
Please check ☑ on either one.

☐ When guardian or representative (escort) comes together and a person who take vaccination is married

☐ When guardian does not come together（Attached agreement is required）

Considering the illness history, health conditions and physical conditions of the vaccination day, having doctor's check up, hearing explanation, reading attached 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 (If the person taking vaccination is married, it is herself) or escort

使用ワクチン	実施場所・接種医師名
☐ サーバリックス ☐ ガーダシル Lot No. (注)有効期限が切れていないか要確認	実施場所 接種医師名
接種量 0．5ml	
接種部位（筋肉内接種） 左・右　上腕　その他（ ）	接種（予診）年月日　年　月　日