You can use this only at designated medical institutions in Adachi City.

Voluntary

Vaccine Screening Questionnaire for the Childhood Influenza

区請求用

住所

氏名

※If this is your second vaccination, please enter the date of your last vaccination.

(A.D.) Y M D

TEL ( )

The city will bear 2,000 yen of the vaccination cost.

Subsidy Amount 2,000 yen

Please fill in the required information in the questions in the bold frame below and also circle (○) either one in the answer box.

Age Category	12 or younger	13 or older
Body temperature before examination	. ℃	

	Questions	Answer		Doctor's Note
1	Have you read the instructions distributed by Adachi City regarding the vaccination you will get today?	No	Yes	
2	We would like to ask you about your child's developmental history. (only for students in the 6th grade or younger)			
	Birth weight ( ) gram — Were there any abnormalities at the time of delivery?	Yes	No	
	Were there any abnormalities after birth?	Yes	No	
	Have you ever been told that there was something abnormal during a baby checkup?	Yes	No	
3	After birth, has the child had any diseases such as congenital anomalies, heart, kidney, liver, cranial nerves, immunodeficiency, or other diseases and has been receiving medical treatment from a doctor (e.g., medications)? Name of disease ( )	Yes	No	
	Has the doctor who is treating the child's disease told you that the child may get vaccinated today?	Yes	No	
4	Does the child feel sick today? Please describe specific symptoms. ( )	Yes	No	
5	Did the child get sick within a month? Name of disease ( )	Yes	No	
6	Has any family member or friend of the child had a disease such as influenza, measles, rubella, chickenpox, or mumps within a month? Name of disease ( )	Yes	No	
7	Has the child got a vaccination within a month? What was that vaccination? (Date of vaccination /)	Yes	No	
8	Has the child ever had an influenza vaccination?	Yes	No	
	Has the child felt unwell at that time?	Yes	No	
9	Has the child ever become sick after vaccination? Name of vaccination ( )	Yes	No	
10	Is the child currently prescribed a special medicine such as a steroid (internal use) and immunosuppressant?	Yes	No	
11	Is the child allergic to chicken meat, eggs, etc.?	Yes	No	
12	Has the child ever had a skin rash or hives or felt unwell after taking medicines or eating foods?	Yes	No	
13	Has the child ever had a seizure (convulsion)? Around ( ) years old	Yes	No	
	Did the child have a fever at that time?	Yes	No	
14	Have any close relatives become sick after getting a vaccination?	Yes	No	
15	Are there any close relatives who have been diagnosed with congenital immunodeficiency?	Yes	No	
16	Do you have any questions about today's vaccination?	Yes	No	
17	(Women only) Are you currently pregnant, or is there a possibility of pregnancy?	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 parent/guardian（If the vaccinated person is16 years of age or older, he/she can fill out the form.）

I have been examined and explained by a doctor and understand the effects and purpose of the vaccination, the possibility of serious side effects,the relief system for injury to health with vaccination, etc. Regarding getting the vaccination,

I （ Agree ・ Do not agree ）

※Circle either one in the parenthesis.

The purpose of this vaccine screening questionnaire is to ensure the safety of vaccination. I understand this and agree to this screening questionnaire being submitted to the city.

Signature of the parent/guardian, or accompanying person

(If 16 years of age or older,he/she can sign.)

使用ワクチン	実施場所・接種医師名
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 足立区内指定医療機関のみ
接種量 該当に☑してください ☐3歳以上 0.5ml ☐3歳未満 0.25ml	接種医師名
接種部位(皮下) 左・右 上腕・大腿	接種(予診)年月日 (西暦) 年 月 日