

This applies only to the vaccination at designated medical institutions in Adachi City.

Voluntary

Vaccine Screening Questionnaire for Mumps

区請求用

Subsidy Amount 4,000 yen

TEL ()

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

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 Does the child feel sick today? Please describe specific symptoms. ()	Yes	No	
3 Did the child get sick within a month? Name of disease ()	Yes	No	
4 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	
5 Has the child got a vaccination within a month? What was that vaccination? () Date of vaccination / ()	Yes	No	
6 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	
7 Is the child currently prescribed a special medicine such as a steroid (internal use) and immunosuppressant?	Yes	No	
8 Has the child ever had a seizure (convulsion)? Around () years old	Yes	No	
Did the child have a fever at that time?	Yes	No	
9 Has the child ever had a skin rash or hives or felt unwell after taking medicines or eating foods?	Yes	No	
10 Are there any close relatives who have been diagnosed with congenital immunodeficiency?	Yes	No	
11 Has the child ever become sick after vaccination? Name of vaccination ()	Yes	No	
12 Have any close relatives become sick after getting a vaccination?	Yes	No	
13 Has the child had a blood transfusion or gamma globulin injection within the last 6 months?	Yes	No	
14 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 parent/guardian

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

使用ワクチン

Lot No.

(注)有効期限が切れていないか要確認

接種量

0. 5ml

接種部位(皮下)

左 上腕
右 大腿

実施場所・接種医師名

実施機関名・住所・電話番号

足立区内指定医療機関のみ

接種医師名

接種(予診)年月日 (西暦) 年 月 日

※(Note) Gamma globulin is a type of blood product that may be administered to prevent infectious diseases such as hepatitis A or for the treatment of serious infectious diseases.

If you have got this injection within the last 3 to 6 months, you may not receive the full effect of the live vaccine inoculation.