Vaccination Register and Vaccine Screening Questionnaire for Chickenpox

То	y's vaccination and vaccination history First Se			Secon	ond			
	Please mark "O" for today's vaccination.	Date of the first Chickenpox vacc	ination. Ye	ar Mo	onth	Day		
Please fill in the necessary items for the questions in the broad lined box and mark "O" on an applicable answer in the answer box. Body temperature								Degrees C
		List of Questions			A	nswer		Doctor's Comment
1	1 Have you read the directions from Adachi City about today's vaccination?					Ye	S	
2	We'd like to ask you about your child's developmental history.							
	Birth weight ()g Did the child have any abnormality at delivery?					No	C	
	Did the child have any abnormality after birth?					No	C	
	Have you ever told that your child had some abnormality at the child's health checkup?					No	c	
3	s the child sick today?					No	_	
	Please write the specific sympt	oms. ()	Yes	INC	5	
4	Has the child been ill in the past month? Name of illness ()					No	С	
5	Has any family member or friend of the child had illness such as measles, rubella,					NI		
	chickenpox or mumps in the past month? Name of illness ()					No	J	
6	Has the child been vaccinated	in the past month?			Vee	N		
	Name of vaccination (Date of vaccina	tion /)	Yes	No	C	
7	Has your child ever had a special disease such as congenital abnormality, or heart, kidney, lever, cerebral nerve disease, immune				Yes			
	ficiency or any other disease for which you have consulted a doctor? Name of the illness (No	C	
	Did the doctor who manages the above	ve disease give a permission to take today's	vaccination?		Yes	No	 С	
8	. Is the child taking a special medicine such as steroid (internal use) and immunosuppressant now?					No	C	
9	Has the child had a seizure (spas	m or fit) in the past? Around () yea	irs old	Yes	No	C	
	Did the child have a fever at that time?					No	 Э	
10	10 Has the child ever had an anthema or hives, or become ill because of the medication or food?					No	С	
11	1 Does the child have a family member or relative with a congenital immunodeficiency?					No	С	
12	2 Has the child ever become ill after the vaccination?							
Name of vaccination (Yes	No	C	
13 Has any family member or relative of the child had a serious reaction to a vaccine in the past?					Yes	No	C	
-	14 Has the child received a blood transfusion or given a gamma globulin in the past 6 months? ※					No	C	
15 Do you have any questions about today's vaccination?					Yes	No	2	
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								
Ent	try column for the guardian 使用ワクチン					接種医師律	名	
	g doctor's checkup, hearing explanation, and understa		実施場所	i				
	and critical side effects of vaccination, and the Relief h Damage by Vaccination, I give a consent to take vac							
(>	Agree • Not agree) %Please circle either one in the parenthesis urpose of this medical questionnaire is to ensure the si	s (注)有効期限が切れて いないか要確認						
	ccination. Understanding the purpose, I agree with sub uestionnaire to the City.	mitting 0.5ml 接種部位(皮下)		i名				

(Note) Gamma globulin is a blood product that may be injected to prevent infections such as type A hepatitis, and to treat severe infections. Certain active vaccines are occasionally less effective in people who have received this product in the preceding 3 to 6 months.

その他(

上腕

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接種(予診)年月日

年

月

日

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Signature of the guardian or

escort