様式第二

インフルエンザ予防接種予診票

診察前の体温	度　　分

住　　所		
氏　　名		男 ・ 女
生 年 月 日	明治 ・ 大正 ・ 昭和　　年　　月　　日生　（満　　歳）	

質　問　事　項	回　答　欄		医師記入欄
今日のインフルエンザの予防接種について市町村から配られている説明書を読みましたか。	はい	いいえ	
今日の予防接種の効果や副反応などについて理解しましたか。	はい	いいえ	
現在、何か病気にかかっていますか。 病 名 （　　）	はい	いいえ	
治療（投薬など）を受けていますか。	はい	いいえ	
その病気の主治医には、今日の予防接種を受けてもよいと言われましたか。	はい	いいえ	
免疫不全と診断されたことがありますか。	はい	いいえ	
今日、体に具合の悪いところがありますか。 具合の悪い症状を書いてください。　（　　）	はい	いいえ	
ニワトリの肉や卵などにアレルギーがありますか。	はい	いいえ	
インフルエンザの予防接種を受けたことがありますか。	はい	いいえ	
①その際に具合が悪くなったことはありますか	はい	いいえ	
②インフルエンザ以外の予防接種の際に具合が悪くなったことはありますか	はい	いいえ	
ひきつけ（けいれん）を起こしたことがありますか。	はい	いいえ	
１カ月以内に予防接種を受けましたか。予防接種の種類（　　）	はい	いいえ	
心臓病、腎臓病、肝臓病、血液疾患などの慢性疾患にかかったことがありますか。 病名（　　）	はい	いいえ	
その病気を診てもらっている医師に今日の予防接種を受けてよいと言われましたか。	はい	いいえ	
最近１ヶ月以内に熱が出たり、病気にかかったりしましたか。 病名（　　）	はい	いいえ	
今日の予防接種について質問がありますか。	はい	いいえ	

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（可能・見合わせる） 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、説明した。 医師署名又は記名押印

ワクチンロット番号	接種量	実施場所・医師名・接種年月日
Lot No.	ｍｌ	実施場所 医師名 接種年月日　　平成　　年　　月　　日

インフルエンザ予防接種希望書（医師の診察の結果、接種が可能と判断された後に記入してください。）

医師の診察・説明を受け、予防接種の効果や目的、重篤な副反応の可能性などについて理解した上で、
接種を希望しますか。　（　接種を希望します・接種を希望しません　）
この予診票は、予防接種の安全性の確保を目的としています。
このことを理解の上、本予診票が市町村に提出されることに同意します。

平成　　年　　月　　日　　被接種者自署 ＿＿＿＿＿＿＿＿

（※自署できない者は代筆者が署名し、代筆者氏名及び被接種者との続柄を記載）

英語版

Form 2

Vaccine Screening Questionnaire for [ ] (infant/schoolchild)

	Body temperature before interview	Degrees

Address				
Child's Name		M	Birth date	Born on / / (d/m/y)
Parent/Guardian's Name		F		Age (years months)

Questionnaire for Vaccination	Answer		Doctor's comment
Have you read the document (sent to you previously by the municipal office) explaining the vaccination that will be administered today?	Yes	No	
Please answer the following questions about the child. Birth Weight Did the child have any abnormal findings at delivery? ( ) g Did the child have any abnormal findings after birth? Was any abnormality identified at an infant health check?	 Yes Yes Yes	 No No No	
Is the child sick today? If so, describe the nature of the illness. ( )	Yes	No	
Has the child been ill in the past month? Disease name ( )	Yes	No	
Has any family member or friend of the child had measles, rubella, chickenpox or mumps in the past month? Disease name ( )	Yes	No	
Has the child been exposed to anyone with tuberculosis (including family members)?	Yes	No	
Has the child been vaccinated in the past month? Vaccine name ( )	Yes	No	
Does the child have a congenital anomaly, heart, kidney, liver, central nerve disease, immune deficiency, or any other diseases for which you have consulted a doctor? Disease name ( )	Yes	No	
Where relevant, did the doctor who manages the above disease agree with today's vaccination?	Yes	No	
Has the child had a seizure (spasm or fit) in the past? If so, at what age did it occur? ( )	Yes	No	
If you answered "yes" to the preceding question, did the child have a fever at that time?	Yes	No	
Has the child ever had a rash or urticaria (hives or 'nettle rash') as a reaction to medications or food or become ill after eating certain foods or receiving certain medications?	Yes	No	
Does the child have a family member or relative with a congenital immunodeficiency?	Yes	No	
Has the child had a serious reaction to a vaccine in the past? Vaccine name ( )	Yes	No	
Has any family member or relative of the child had a serious reaction to a vaccine in the past?	Yes	No	
Has the child received a transfusion of blood or blood products or been given a medicine called gamma globulin in the past 6 months?	Yes	No	
Do you have any questions about today's vaccination?	Yes	No	
Doctor's comment Based on the above answers and the results of interview, I have decided that the child (can / should not) receive a vaccination today. I have explained to the parent/guardian the information concerning the benefits and side effects of vaccination and the support provided to people who have had adverse events associated with vaccination. Signature or Name and Seal of Doctor:			

This screening questionnaire is used to improve the safety of vaccination. The child has been interviewed by the doctor, and information concerning the benefits, objectives, and risks (including serious side effects) of vaccination has been explained to me by the doctor, as has the nature of support provided if adverse events occur. I believe that I understand this information.

I (do / do not)* give consent for the child to be vaccinated. * Please circle your choice.

I understand the above and agree that this questionnaire can be submitted to the municipal office.

Signature of Parent / Guardian:

Vaccine Name	Dosage	Institution / Doctor Name / Date Administered
Vaccine Name Lot Number [Caution] Confirm that the expiration date of the vaccine is valid.	* (Subcutaneous injection) mL	Institution: Doctor Name: Date Administered: / / (d/m/y)

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

* In the case of BCG vaccination, describe, for example, "percutaneous vaccination using a BCG apparatus with multiple needles at a specified volume."

英語版

Form 3

Vaccine Screening Questionnaire for Human Papilloma Virus Infection

		Body temperature before interview		Degrees
Address				
Patient's Name		M	Birth date	Born on / / (d/m/y)
Parent/Guardian's Name*		F		Age (years months)

* Parent/Guardian's Name is not necessary if the patient is 16 years or older.

Questionnaire for Vaccination		Answer		Doctor's comment
Have you read the document (sent to you previously by the municipal office) explaining the vaccination that will be administered today?		Yes	No	
Has the patient received this vaccination before?		No, this is the 1st dose. Yes, this is the 2nd dose. Yes, this is the 3rd dose.		
If "yes," please enter the type of vaccine, the date received, and the patient's age at the time of vaccination. [Caution 1] Circle one of the following vaccines: **(1) Cervarix (bivalent); (2) Gardasil (quadrivalent); (3) Silgard 9 (9-valent); (4) Other**. [Caution 2] In the case of **(3) Silgard 9 (9-valent)**, a two-dose regimen can also be followed, consisting of the first dose being received by age 14 and the second after an interval of at least 5 months. [Caution 3] The parent/guardian, patient, and/or doctor should strive to identify the vaccine received. If records cannot be retrieved and the vaccine cannot be identified, the doctor is to enter "Unknown."	1st dose	(/ / ,) (d/m/y, age) (1) / (2) / (3) / (4)		
	2nd dose	(/ / ,) (d/m/y, age) (1) / (2) / (3) / (4)		
Which vaccine do you wish the patient to receive today? [Caution] Circle one of the following vaccines: **(1) Cervarix (bivalent); (2) Gardasil (quadrivalent); (3) Silgard 9 (9-valent)**.		(1) / (2) / (3)		
Is the patient sick today? If so, please describe in detail. ( )		Yes	No	
Has the patient been ill in the past month? Disease name ( )		Yes	No	
Has the patient been vaccinated in the past month? Vaccine name ( )		Yes	No	
Does the patient have a congenital anomaly, heart, kidney, liver, central nerve disease, immune deficiency, or any other diseases for which you have consulted a doctor? Disease name ( )		Yes	No	
Where relevant, did the doctor who manages the above disease agree with today's vaccination?		Yes	No	
Has the patient had a seizure (spasm or fit) in the past? If so, at what age did it occur? ( )		Yes	No	
If you answered "yes" to the preceding question, did the person have a fever at that time?		Yes	No	
Has the patient ever had a rash or urticaria (hives or 'nettle rash') as a reaction to medications or food or become ill after eating certain foods or receiving certain medications?		Yes	No	
Does the patient have a family member or relative with a congenital immunodeficiency?		Yes	No	
Has the patient had a serious reaction to a vaccine in the past?		Yes	No	
Vaccine name ( )				
Has any family member or relative of the patient had a serious reaction to a vaccine in the past?		Yes	No	
Is there a chance the child could become pregnant (for example, has menstruation been delayed or has a period been missed)? **[Caution]** Strict attention should be paid to vaccinations for pregnant women.		Yes	No	
Do you have any questions about today's vaccination?		Yes	No	
Doctor's comment Based on the above answers and the results of interview, I have decided that the patient (can / should not) receive a vaccination today. I have explained to the patient herself (or the parent/guardian if the patient is under 16 years of age) the information concerning the benefits and adverse reactions of vaccination and the support provided by Relief System for Injury to Health with Vaccination. Signature or Name and Seal of Doctor:				

This screening questionnaire is used to improve the safety of vaccination. The patient has been interviewed by the doctor, and information concerning the benefits, objectives, and risks (including serious side effects) of vaccination has been explained to me by the doctor, as has the nature of support provided if adverse events occur. I believe that I understand this information.

I (do / do not)* give consent for the patient to be vaccinated.

Please circle your choice.

I understand the above and agree that this questionnaire can be submitted to the municipal office.

Signature of the parent/guardian or the patient herself:_____

(*Signature of the parent/guardian is necessary, if the patient is under 16 years of age)

Vaccine Name	Dosage	Institution / Doctor Name / Date Administered
Vaccine Name Lot Number [Caution] Confirm that the expiration date of the vaccine is valid.	Intramuscular injection 0.5 mL	Institution: Doctor Name: Date Administered: / / (d/m/y)

英語版

Form 4

Vaccine Screening Questionnaire for Human Papilloma Virus Infection (For child not accompanied by parent / guardian)

Explanation prior to vaccination against human papilloma virus infection

○ For the parent/guardian: Please be sure to read this document.

*** [For the parent/guardian of a child for vaccination who is at the age corresponding from the sixth grade of elementary school to the first grade of high school (except for children aged 16 or older)]**

The parent/guardian was previously required to accompany their child who was receiving a vaccination; however, only in the case of vaccination against human papilloma virus infection for children aged 13 years or older (from the first grade of junior high school to the first grade of high school (except for children aged 16 or older)), can such children receive vaccines despite not being accompanied by their parent/guardian, provided the parent/guardian has read, understood, and signed this document permitting their child to be vaccinated.

(Please make sure your child brings this document on the day of vaccination.)

Before signing this screening questionnaire, if you have any questions about the vaccination, please consult your doctor, healthcare center, or the municipal office in charge of vaccination so that you fully understand the benefits and risks of vaccination before making a decision about vaccination.

1 Symptoms of human papilloma virus (HPV) infection

Human papilloma virus, a virus which can infect the skin and mucosa, is classified into more than 100 types. Viruses infecting the mucosa mainly invade genital mucosa through a small wound on the mucous membrane caused by sexual intercourse. More than 50% of women abroad with intercourse experience are estimated to be infected by these viruses at least once in their life.

Of HPV infecting the mucosa, at least 15 types are detected in cervical cancer and called "high-risk HPV". Two particularly high-risk HPV, Type 16 and 18, are frequently detected and studies indicate that the two viruses were involved in about 70% of cervical cancer cases abroad. In addition to cervical cancer, at least 90% of anal cancer and 40% of vaginal, vulvar and penile cancer are suspected to be connected with the two viruses abroad. Viruses not classified into high-risk categories are confirmed to cause condyloma acuminatum, a benign genital wart.

2 Benefits and side effects of vaccination

Vaccine includes viral components of several types of human papilloma viruses (HPVs) and vaccinated children acquire immunity to these viruses. A child who is immune is protected from HPVs.

However, vaccination occasionally causes mild side effects. Vaccination very rarely causes serious side effects. Reactions sometimes seen after vaccination are as follows.

Main side effects of HPV vaccine

Main side effects include fever and local reactions (pain, erythema and swelling). Syncope due to pain and psychogenic reaction induced by injection sometimes occur after vaccination. To prevent falling down due to syncope, vaccinated children should be seated on a sofa and observed for about 30 minutes.

On rare occasions serious side effects have been reported, including an anaphylactic reaction (even shock, hives, and difficulty breathing), Guillain-Barre syndrome, thrombocytopenic purpura (bleeding into the skin, from the nose and oral mucosa) and acute disseminated encephalomyelitis (ADEM).

* For details, please refer to your municipality's website or information leaflet mailed individually.

3 Systems to support people with adverse events associated with vaccination

○ A person with side effects caused by routine vaccination who requires medical treatment or whose ability to perform normal daily activities is impaired due to injury can be compensated by the government according to the Preventive Vaccination Law.

○ The compensation consists of payment of medical expenses, medical benefits, an annuity for disabled children, a disability annuity, lump-sum death benefits, and funeral expenses, which are classified by law according to the severity of the injury. Respective compensation is paid according to the provisions of the law. All compensation, except lump-sum death benefits and funeral expenses, is continuously paid until the completion of treatment or the improvement in health.

○ Compensation is paid to the patient after the relevant injury is certified by the governmental review committee to be caused by vaccination. This committee comprises specialists in vaccination, infectious medicine, law, and other relevant disciplines, who discuss the causal relationship of the relevant injury with vaccination, that is, whether the relevant injury is caused by vaccination or other factors (infection before or after vaccination, or other causes).

* If you believe you need to submit an application for compensation, consult the doctor who interviewed your child before vaccination, the healthcare center, or the municipal office in charge of vaccination.

英語版

4 Cautions for vaccination

Vaccination should generally be given to a child in good health. If your child is unwell, please consult your doctor and decide whether your child should be vaccinated.

When your child meets any of the following criteria, she cannot receive a vaccination.

1) Obvious fever (37.5°C or higher)
2) Severe acute illness
3) A history of anaphylaxis caused by any component of the vaccine preparation
4) Other conditions that a doctor considers inappropriate

If your child is pregnant, she should not be vaccinated.

○ For the parent/guardian: Please be sure to read this following.

After carefully reading and fully understanding the above, please decide whether or not to have your child vaccinated. If you decide on vaccination, please sign the following, in the column for parent/guardian. **(Without your signature, your child is not permitted to receive a vaccination if she is under 16 years of age.)**

If you do not want your child vaccinated, you do not need to sign.

I have read the explanation for vaccination against human papilloma virus infection and I understand the benefits and risks of serious side effects due to vaccines, as well as the relief system for supporting people who sustain a health injury caused by vaccination. Considering these issues, I agree to have my child vaccinated.

I understand that this document has been drawn up to help parents and guardians understand vaccination thoroughly and agree that this form can be submitted to the municipal office.

Signature of Parent / Guardian: _____

Address: _____

Emergency contact number: _____

* This form is necessary for vaccination against human papilloma virus infection when a child is not accompanied by parent/guardian. Make sure your child submits this form if she is under 16 years old and unaccompanied when receiving the vaccination.

Without your signature on the form, your child is not permitted to receive a vaccination if she is under 16 years of age.

英語版

Screening Questionnaire

				Body temperature before interview	Degrees
Address					
Child's Name		M F	Birth date	Born on / / (d/m/y) Age (years months)	

Questionnaire for Vaccination		Answer		Doctor's comment
Have you read the document (sent to you previously by the municipal office) explaining the vaccination that will be administered today?		Yes	No	
Has the patient received this vaccination before?		No, this is the 1st dose. Yes, this is the 2nd dose. Yes, this is the 3rd dose.		
If "yes," please enter the type of vaccine, the date received, and the patient's age at the time of vaccination. [Caution 1] Circle one of the following vaccines: **(1) Cervarix (bivalent); (2) Gardasil (quadrivalent); (3) Silgard 9 (9-valent); (4) Other**. [Caution 2] In the case of **(3) Silgard 9 (9-valent)**, a two-dose regimen can also be followed, consisting of the first dose being received by age 14 and the second after an interval of at least 5 months. [Caution 3] The parent/guardian, patient, and/or doctor should strive to identify the vaccine received. If records cannot be retrieved and the vaccine cannot be identified, the doctor is to enter "Unknown."	1st dose	(/ / ,) (d/m/y, age) (1) / (2) / (3) / (4)		
	2nd dose	(/ / ,) (d/m/y, age) (1) / (2) / (3) / (4)		
Which vaccine do you wish the patient to receive today? [Caution] Circle one of the following vaccines: **(1) Cervarix (bivalent); (2) Gardasil (quadrivalent); (3) Silgard 9 (9-valent)**.		(1) / (2) / (3)		
Is the child sick today? If so, describe the nature of the illness. ( )		Yes	No	
Has the child been ill in the past month? Disease name ( )		Yes	No	
Has the child been vaccinated in the past month? Vaccine name ( )		Yes	No	
Does the child have a congenital anomaly, heart, kidney, liver, central nerve disease, immune deficiency, or any other diseases for which you have consulted a doctor? Disease name ( )		Yes	No	
Where relevant, did the doctor who manages the above disease agree with today's vaccination?		Yes	No	
Has the child had a seizure (spasm or fit) in the past? If so, at what age did it occur? ( )		Yes	No	
If you answered "yes" to the preceding question, did the child have a fever at that time?		Yes	No	
Has the child ever had a rash or urticaria (hives or 'nettle rash') as a reaction to medications or food or become ill after eating certain foods or receiving certain medications?		Yes	No	
Does the child have a family member or relative with a congenital immunodeficiency?		Yes	No	
Has the child had a serious reaction to a vaccine in the past? Vaccine name ( )		Yes	No	
Has any family member or relative of the child had a serious reaction to a vaccine in the past?		Yes	No	
Is there a chance she is pregnant (for example, has menstruation been delayed, or has a period been missed)? [**Caution**] Strict attention should be paid to vaccinations for pregnant women.		Yes	No	
This screening questionnaire is used to improve the safety of vaccination. Do you agree to the vaccination of your child, taking into consideration past illnesses and how they are today? I (do / do not)* agree to have the child vaccinated. * Please circle your choice. I understand the above and agree that this questionnaire can be submitted to the municipal office. Signature of Parent / Guardian:				

Doctor's comment

Based on the above answers and the results of the interview, I have decided that the patient (can / should not) receive a vaccination today.

I have explained to the patient herself the information concerning the benefits and side effects of vaccination and the support provided to people who have had adverse events associated with vaccination.

Signature or Name and Seal of Doctor:

Vaccine Name	Dosage	Institution / Doctor Name / Date Administered
Vaccine Name Lot Number [Caution] Confirm that the expiration date of the vaccine is valid.	Intramuscular injection 0.5 mL	Institution: Doctor Name: Date Administered: / / (d/m/y)

英語版

Form 8

Hepatitis B Vaccine Screening Questionnaire

		Body temperature before interview		Degrees
Address				
Child's Name		M	Birth date	Born on / / (d/m/y)
Parent/Guardian's Name		F		Age (years months)

Questionnaire for Vaccination	Answer		Doctor's comment
Have you read the document (sent to you previously by the municipal office) explaining the vaccination that will be administered today?	Yes	No	
Please answer the following questions about the child. Birth Weight ( ) g Did the child have any abnormal findings at delivery? Did the child have any abnormal findings after birth? Was any abnormality identified at an infant health check?	Yes Yes Yes	No No No	
Is the child sick today? If so, describe the nature of the illness. ( )	Yes	No	
Has the child been ill in the past month? Disease name ( )	Yes	No	
Has any family member or friend of the child had measles, rubella, chickenpox or mumps in the past month? Disease name ( )	Yes	No	
Has the child been vaccinated in the past month? Vaccine name ( )	Yes	No	
Does the child have a congenital anomaly, heart, kidney, liver, central nerve disease, immune deficiency, or any other diseases for which you have consulted a doctor? Disease name ( )	Yes	No	
Where relevant, did the doctor who manages the above disease agree with today's vaccination?	Yes	No	
Has the child had a seizure (spasm or fit) in the past? If so, at what age did it occur? ( )	Yes	No	
If you answered "yes" to the preceding question, did the child have a fever at that time?	Yes	No	
Has the child ever had a rash or urticaria (hives or 'nettle rash') as a reaction to medications or food or become ill after eating certain foods or receiving certain medications?	Yes	No	
Has the child a Latex sensitivity?*	Yes	No	
Does the child have a family member or relative with a congenital immunodeficiency?	Yes	No	
Has the child had a serious reaction to a vaccine in the past? Vaccine name ( )	Yes	No	
Has any family member or relative of the child had a serious reaction to a vaccine in the past?	Yes	No	
Has the child received a transfusion of blood or blood products or been given a medicine called gamma globulin in the past 6 months?	Yes	No	
Did the child receive the hepatitis B vaccine after birth as part of the mother-to-infant transmission prevention program?	Yes	No	
Do you have any questions about today's vaccination?	Yes	No	

Doctor's comment
Based on the above answers and the results of interview, I have decided that the child (can / should not) receive a vaccination today.
I have explained to the parent/guardian the information concerning the benefits and side effects of vaccination and the support provided to people who have had adverse events associated with vaccination.

Signature or Name and Seal of Doctor:

This screening questionnaire is used to improve the safety of vaccination. The child has been interviewed by the doctor, and information concerning the benefits, objectives, and risks (including serious side effects) of vaccination has been explained to me by the doctor, as has the nature of support provided if adverse events occur. I believe that I understand this information.
I (do / do not)* give consent for the child to be vaccinated. * Please circle your choice.
I understand the above and agree that this questionnaire can be submitted to the municipal office.

Signature of Parent / Guardian:

Vaccine Name	Dosage	Institution / Doctor Name / Date Administered
Vaccine Name Lot Number [Caution] Confirm that the expiration date of the vaccine is valid.	* (Subcutaneous injection) mL	Institution: Doctor Name: Date Administered: / / (d/m/y)

(Note) Latex sensitivity is an immediate hypersensitivity to natural rubber products. The condition is suspected when an allergic reaction is observed upon the use of latex gloves. Also seek consultation if there is an allergy to fruits etc. with cross-reactivity to latex (banana, chestnut, kiwifruit, avocado, melon, etc.).

英語版

Form 10

Rotavirus Vaccine Screening Questionnaire

Parent/guardian: Please fill out the bolded fields.

Address			**Date**	/ / (YYYY/MM/DD)
			Pre-exam temperature	degrees (include decimal)
			Phone no.	– –
Child's name		**M / F**	**Child's date of birth**	/ / (YYYY/MM/DD)
Parent/guardian's name				(Age: weeks days) **For age in weeks and days, count the day after the date of birth as day 1.**

If this is the first vaccination, have you confirmed that the child is not older than 14 weeks and 6 days as of today?	Field for medical institution to enter (Mark a ☑)

Questionnaire	Answer			Doctor's comment
Which vaccination will your child receive today?	1st	2nd	3rd	
Please write the date(s) of the vaccination(s) your child has received so far (answer only if this is your child's 2nd or 3rd vaccination). Note: Confirm that at least 27 days have passed since your child's last rotavirus vaccination.	1st / / (YYY/MM/DD)			
	2nd / / (YYY/MM/DD)			
Have you read the document provided by the municipal office explaining the vaccination that will be administered today?	Yes	No		
Do you understand the benefits and side effects of the vaccination that will be administered today?	Yes	No		
Were you provided with information concerning intussusception, and did you understand that information?	Yes	No		
The following questions concern your child's growth and development. Birth weight: g				
Were there any abnormalities at the time of delivery?	Yes	No		
Have there been any abnormalities after birth?	Yes	No		
Have any abnormalities been identified in an infant health exam?	Yes	No		
Is your child experiencing any illness or does your child feel unwell today? Please describe the symptoms:	Yes	No		
Has your child been sick within the last month?	Yes	No		
Name of illness:				
Has any family member or friend of the child had measles, rubella, chickenpox, or mumps in the past month? Name of illness:	Yes	No		
Has your child been vaccinated within the past month? Vaccine: Date: (YYYY/MM/DD)	Yes	No		
Has your child experienced intussusception before? Or does your child have an untreated congenital abnormality of the gastrointestinal tract? Note: If yes, your child cannot receive the rotavirus vaccine.	Yes	No		
Has your child been diagnosed with immunodeficiency? Or has your child experienced repeated diarrhea, repeated infections such as pneumonia or middle ear infections, or had difficulty gaining weight? Note: If yes, your child may not be able to receive the rotavirus vaccine.	Yes	No		
Does your child have a congenital anomaly; gastrointestinal disorder; heart, kidney, liver, blood, or central nervous disease; or any other diseases for which you have consulted a doctor? Name of illness:	Yes	No		
If you answered yes to the previous question, have you been told by the doctor whom your child is seeing for that disease that your child may receive today's vaccination?	Yes	No		
Has your child had a seizure (spasm or fit) in the past? If so, at around how many months of age: months	Yes	No		
If you answered yes to the previous question, did your child have a fever at that time?	Yes	No		
Has your child ever had a rash or hives or become ill after eating certain foods or receiving certain medications?	Yes	No		
If you answered yes to the previous question, name of medication/food:				
To date, has your child ever felt ill after receiving a vaccination?	Yes	No		
If you answered yes to the previous question, name of vaccine:				
Did the mother take medication which suppresses the immune system while pregnant with the child?	Yes	No		
If you answered yes to the previous question, name of medication:				
Has a close relative of your child been diagnosed with a congenital immunodeficiency?	Yes	No		
Has a close relative of your child ever felt ill after receiving a vaccination?	Yes	No		
To date, has your child received a blood transfusion or been injected with gamma globulin?	Yes	No		
Do you have any questions about today's vaccination?	Yes	No		

Field for doctor to enter

Based on the above questionnaire and the results of the medical examination, I have decided that the child **(can / should not)** receive today's vaccination.
I have explained to the parent/guardian the information concerning the benefits and side effects of vaccination (particularly intussusception) and the Relief System for Injury to Health with Vaccination.

Signature or name and seal of doctor:

Field for parent/guardian to enter

My child has been examined by and I have been provided with information by the doctor. I understand the benefits, objectives, possibility of serious side effects (particularly intussusception), and information concerning the Relief System for Injury to Health with Vaccination, and accordingly I **(do / do not)*** give consent for my child to be vaccinated. * Please circle your choice.
I understand that the purpose of the questionnaire is to ensure the safety of vaccinations and I agree that this questionnaire can be submitted to the municipal office.

Signature of parent/guardian:

Vaccine used	Dosage		Place of vaccination/doctor's name/date of vaccination
Vaccine name:	**Oral vaccination**		Place of vaccination:
Lot no.:	RotaTeq® 2 ml	Rotarix® 1.5 ml	Doctor's name:
Warning: Confirm that expiration date of vaccine is valid			Date of vaccination: / / (YYYY/MM/DD)