R	otavirus (ロ	タウイルス) vaccir	ne: Vad	cination Regi	ister a	and Screening	Ques	tionr	naire	
Address	北区									
Patient's name			М	Date of birth:				ア	1 [回目
			F					1	2 [2回目
			Г	Age: ye	ears	months		·	·	
Parent/guardian name		Phone					ウ	3 [回目	
Vaccination history - Mark√ on the box. ☐ First time vaccination ☐ Second time vaccination								☐ Third time vaccination		
Circle type of vaccination you took.		(RotarixRV 1 · RotaTe			rixRV 1 • RotaTeq RV5)			(1	RotaTeq	RV5)
Fill in the date of previous	s vaccination	Year Month Day		Year N	Year Month Day					
*If you are unsure of the va	accination, you have	not past14weeks and 6days after e received so far, show your doc		ord of your vaccination	n in the n	naternal and child Hea	alth handb	ook or	vaccinat	ion record sheet or
check with the medical institution that you vaccinated last time. Please fill in the question items in the bold box below and circle one of the answer columns. Body temperature before in							efore inter	rview		°C
Questionnaire for Vaccination								Ans	swer	Doctor's comment
Have you read the document (sent to you previously from your city) about the vaccination that will be administered today?								No	Yes	
Did you understand the effects and side reactions of vaccination today?								No	Yes	
Were you explained about an intussusception and understand it?								No	Yes	
Please answer about your child's development history.										
Birth weight () gram Did the child have abnormal findings at delivery?								Yes	No	
Did the child have any abnormal findings after birth? Have you ever been told any abnormal findings at an infant health check?								Yes Yes	No No	
5. Is the child sick today?								Yes	No	
If so, describe the specific symptoms. (
6. Did the child have a disease within the last one month? Name of disease (Yes	No	
7. Has any family member or friend of the child had disease such as measles, rubella, chickenpox or mumps within one month? Name of disease: ()								Yes	No	
Has the child been vaccinated in the past month? Name of vaccination (Date of vaccination; /)								Yes	No	
9. Has the child had an intussusception in the past? * If Yes, the child cannot take vaccination.								Yes	No	
10. Are there congenital gastrointestional disorders that have not been treated? * If Yes, the child cannot take vaccination.								Yes	No	
11. Has the child ever been diagnosed with an immune deficiency, had infectious disease such as pneumonia or otitis media, had repeated diarrhea, or had a poor weight gain?										
12. Does the child have a congenital anomaly, heart, kidney, liver, central nerve disease, immune deficiency, or any other diseases for which you								Yes	No	
have consulted a doctor? Name of disease ()			
Has the doctor treating disease told you that the child could have the vaccination today?								Yes	No	
13. Has the child had a seizure (spasm or fit) in the past? If Yes: age () years old. Did the child have a fever at that time?								Yes Yes	No No	
14. Has the child ever had a rash or hives or become ill because of the medications or food?								Yes	No	
15. Does the child have a family member or relative with a congenital immunodeficiency?								Yes	No	
16. Has the child ever become ill after the vaccination?								Yes	No	
								Yes	No	
18. Did the mother receive any immunosuppressive medications during her pregnancy? Name of medicine(19. Do you have any question about the vaccination?)	Yes Yes	No No	
医師記入欄								163	NO	
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										
Entry column for parent/g	uuardian [.]		使	用ワクチン		宝柏	場所・投	全種医	新名	
I have been interviewed and explained by the doctor. I have understood 該当に√してください 実施機関名・住所・電話番号										
the benefit, objectives, and risk of serious side effects, and also the Relief ロタテック(5価)2mL 〒114-0003										
System for Health Damage by Vaccination. Now, I confirm my intent on Lot No. 東京都北区豊島 5-5-5-107							-107			
taking vaccination as follows.										
(Agree ・ Not agree) 電話 03-3927-3778										
I This screening guestions	naire is used to imp	rove the safety of vaccination	E()	E)有効期限が切れて	1					

いないか要確認

経口接種

接種医師名

接種(予診)年月日 年 月 日

I understand the above and agree that this questionnaire can be submitted

Signature of Parent/Guardian or Companion