Kamogawa

This is an example form. Please use this to fill out the actual form.

Rotavirus Vaccine: Health History Check

There are ⑪ spaces to fill in.

Ages： [Rotatrix] 6～24 weeks old (2 shots: 1st shot 6-14 weeks and 6 days) [Rota Teq] 6～32 weeks old (3 shots: 1st shot 6-14 weeks and 6 days)

Address	① Kamogawa Yokosuka 1450	Date of vaccination: 2021 / 6 / 1 ②	Temperature date of Vaccination: 36.7 ℃ ③
		Phone number	④ 090 – 2330 - 3761
		Sex: ⑥ (M) · F	Birthdate (yyyy/mm/dd) (Age): ⑦ 2021 / 4 / 2 (8 weeks 4 days)
Child's Name	⑤ John Smith	Parent/ Guardian Name	⑧ Emily Smith

Read the questions on the left and circle your answer

Pre-Vaccination Health History Check	Answer		Doctor's Comment
Which shot will you be getting today? (Please circle one) ⑨	1st · 2nd · 3rd		
(For children getting 2nd or 3rd shot only) Please write the dates (yyyy/mm/dd) of the previous shots. ※There must be at least 27 days in between the vaccination days。	1st 2nd	/ / / /	
Have you read the document (sent to you previously by the city hall) explaining the vaccination that will be administered today?	No	Yes	
Did you understand the explanation about vaccination and the potential affects of getting a vaccine?	No	Yes	
Did you understand the explanation of intussusception/indigitation?	No	Yes	
Your child's weight at birth（ ）g Were there any abnormalities or complications at the time of delivery? Have there been any abnormalities since birth? Have there been any abnormalities found at your infant's health check?	 Yes Yes Yes	 No No No	
Is your child experiencing any illness or does your child feel unwell today? (Please explain:)	Yes	No	
Has your child been sick within the last month? (Name of illness:)	Yes	No	
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 ever had intussusception? Or do they have a disability related to an untreated congenital alimentary canal condition. ※If yes, you will not be able to get the Rotavirus vaccination.	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 heart, kidney, liver, blood, central nervous, or an immunodeficiency disease; or any other diseases for which you have consulted a doctor? Name of illness:	Yes	No	
If "yes", have you been told by the doctor that your child may receive today's vaccination?	No	Yes	
Has your child had a seizure (spasm or fit) in the past? If so, at around how many months of age:	Yes	No	
If yes, did your child have a fever at that time?	No	Yes	
Has your child ever had a rash or hives or become ill after eating certain foods or receiving certain medications? What age? ( ) What Food or Medicine: ( ) What happened? ( )	Yes	No	
To date, has your child ever felt ill after receiving a vaccination? (If yes, vaccine:)	Yes	No	
Has your child ever received a blood transfusion or been injected with gamma globulin?	Yes	No	
Did the mother take medication which suppresses the immune system while pregnant with the child? (If yes, what medicine:)	Yes	No	
Has anyone in your family been diagnosed with a congenital immunodeficiency disease?	Yes	No	
Has a close relative of your child ever felt ill after receiving a vaccination?	Yes	No	

Do you have any questions about today's vaccination? If yes, please write: ( )	Yes	No

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:

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。 ⑩

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: ⑪ Emily Smith