Kamogawa

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

(2nd Dose) Japanese Encephalitis Vaccine: Health History Check

Ages： 9 ～ 12 years old 11 months

There are ⑫ spaces to fill in.

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	Birthdate (yyyy/mm/dd) (Age)
Child's Name	⑤ John Smith	⑥ M ・ F	⑦ 2012 / 4 / 2 (9 years 1 months)
		Parent/ Guardian Name	⑧ Emily Smith

⑨ No. of shots received ・ when (yyyy/mm/dd) : 1st time (2021 / 6 / 1) 2nd time (/ /) [Additional shots] (/ /) (2nd dose)

Pre-Vaccination Health History Check	Answer		Doctor's Comment
Have you read the document (sent to you previously by the city hall) explaining today's vaccination? ⑩	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 o illness：)	Yes	No	
Has your child been vaccinated within the past month? Vaccine: Date (YYYY/MM/DD): / /	Yes	No	
Does your child have a heart, kidney, liver, blood, central nervous, or immunodeficiency disease; or any other diseases? 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	
Has a close relative ever been diagnosed with a congenital immunodeficiency?	Yes	No	
To date, has your child ever felt ill after receiving a vaccination? (If yes, vaccine:)	Yes	No	
Has a close relative of your child ever felt ill after receiving a vaccination?	Yes	No	
Within the past 6 months, has your child received a blood transfusion or been injected with gamma globulin?	Yes	No	
Do you have any questions about today's vaccination? If yes, please write: （ ）	Yes	No	

Read the questions on the left and circle your answer

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。 ⑪

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:

⑫ Emily Smith