# IMMUNIZATION　QUESTIONNAIRE/CONSENT FORM (15 years old or younger)

**Today's vaccine is(　　)**　Body Temperature　　℃

| | |
|---|---|
| Name | male ・ female |
| Date of birth　year　month　day | Age　years　months |
| Address | |
| Name of parent /guardian | |

| | |
|---|---|
| 1. Have you read the literature provided, which outlines the benefits of vaccine as well as the possible side effects? | NO/ YES |
| 2. Birth weight (　　) kg | |
| 3. Were there some unusual conditions either at delivery or after birth ? | YES/NO |
| 4. Were you informed of any extraordinary conditions or maldevelopement of your child at well-baby check-up? | YES/NO |
| 5. Do you have any concerns about your child's health today?<br>If yes, please specify (　　) | YES/NO |
| 6. During the past1 month, did your child get sick? Please specify (　　) | YES/NO |
| 7. Has your child ever had an allergic reaction against a particular food (e.g. egg), some medicines (e.g. antibiotics), or some substances (e.g. latex, aluminum, formalin)? Please specify (　　) | YES/NO |
| 8. During the past 4 weeks, did your child receive any vaccination?<br>Please specify (　　) | YES/NO |
| 9. Has your child ever had being treated for any of the following conditions: Congenital abnormality, Bronchial asthma, Interstitial pneumonia, a Heart, Kidney, Liver, Brain, Nerve, or Immunity Disorder, Epilepsy, Other?<br>If yes, please specify (　　) | YES/NO |
| 10. Has the doctor who is treating the above disease approved of your child receiving the immunization today? | NO/ YES |
| 11. Has your child ever had convulsions? At what age?　Age (　　)<br>Did he/she have a fever at that time? | YES/NO<br>YES/NO |
| 12. Have some of your children been diagnosed with a Congenital Immunodeficiency? | YES/NO |
| 13. Has your child ever felt ill after vaccination?<br>If yes, please specify (　　) | YES/NO |
| 14. Have someone in your family ever felt ill after vaccination? | YES/NO |
| 15. During the past 1 month, did you come into contact with someone who had measles, rubella, chicken pox, or mumps?　Please specify (　　) | YES/NO |
| 16. During the past 6 months, did your child get transfusion either of blood or of Gamma Globulin? | YES/NO |
| 17. Do you have any questions regarding today's immunization? | YES/NO |

Based on the results of the questionnaire, today's immunization should be　(　given　/　postponed )

Doctor's signature

I understand the benefits of the today's vaccine as well as the possible side effects.

I would like my child to receive the today's vaccination.　Signature of Parent/Guardian

| Vaccine given | Dosage | Vaccination site and Doctor |
|---|---|---|
| Name of the Vaccine:<br>Lot No.: | Hypodermic inoculation<br>ml | 東京都府中市若松町 3-35-7　えはら医院　　江原　寛<br>Date　year　month　day |

(Note)Gamma Globulin is a blood product that is used for prevention against some contagious diseases such as type A hepatius or a treatment for some serious diseases. Those who have received Gamma Globulin within the last six months can get immunized less than designated effectiveness for some vaccination such as measles.