（請求用）

Vaccine Screening Questionnaire for the Childhood Influenza(pernasal)

江東区

Adress

Name

SAMPLE

1st	Subsidy Amount 4,000yen
From 2025/10/1 to 2026/1/31	

Birth date	born on / / (d/m/y)	Sex	M F	※If this is your second vaccination, please enter the date of your last vaccination. / / (d/m/y)

Please fil in the required information in the questions in the bold frame below also circle(○) either one in the answer box.

Body temperature before examination ℃

Questions		Answer		Doctor's Note
Is the child two years of age or older?		Yes	No	
We would like to ask you about your child's history.(only for students in the 7th grade or younger)				
Birth weight ( ) gram	Were there any abnormalities at the time of delivery?	Yes	No	
	Were there any abnormalities after birth?	Yes	No	
Have you ever been told that there was something abnormal during baby checkup?		Yes	No	
Does the child feel sick today? Please describe specific symptoms.( )		Yes	No	
After birth,has the child had any diseases such as congenital anomalies,heart,kidney,liver,cranial nerves,immunodeficiency,or other diseases and has been receiving medical treatment from a doctor? Name of Disease( )		Yes	No	
Has the doctor who is treating the child's disease told you that the child may get vaccinated today?		Yes	No	
Did the child get sick within a month? Name of diseease( )		Yes	No	
Has any family member or friend of the child had a disease such as influenza,measles,rubella, chickenpox,or mumps within a month? Name of disease( )		Yes	No	
Has the child got a vaccination within a month? What was that vaccination? (Date of vaccination /)		Yes	No	
Has the child ever had an influenza vaccination?		Yes	No	
Has the child felt unwell at that time?		Yes	No	
Has the child ever become sick after vaccination? Name of vaccination( )		Yes Yes	No No	
Is the child allergic to chicken meat,eggs,gelatine,etc?		Yes	No	
Has the child ever had a skin rash or hives or felt unwell after taking medicines or eating foods?		Yes	No	
Has the child ever had a seizure(convulsion)? Around( )years old		Yes	No	
Did the child have a fever at that time?		Yes	No	
Have any close relatives become sick after getting a vaccination?		Yes	No	
Are there any close relatives who have been diagnosed with congenital immunodeficiency?		Yes	No	
(Women only)Are you currently pregnant,or is there a possibility of pregnancy?		Yes	No	
Do you have any questions about today's vaccination?		Yes	No	

医師記入欄	※ 上記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。 本人または保護者に対して、予防接種の効果・目的、接種するワクチンの有益性及び副反応並びに医薬品医療機器総合機構法に基づく救済について説明しました。また、本剤の接種対象者が２歳以上であることを確認しました。 医師署名または記名押印

I have been examined and by a doctor and understand the effects and purpose of the vaccination, the possibilist of serious side effects,the relief system for injury to health with vaccination,etc.

Regarding getting the vaccination, **I (Agree ・ Do not agree)**※Circle either one in the parenthesis.

The purpose of this vaccine screening questionnaire is to ensure the safety of vaccination.I understand this and agree to this screening questionnaire being submitted to the city.

Signature of the parent

使用ワクチン名	接　種　量	実施場所・接種医師名・接種年月日
経鼻弱毒生インフルエンザワクチン Lot No.	点鼻0.2ml （各鼻腔0.1ml噴霧）	実施機関名・住所・電話番号 接種医師名 接種年月日　年　月　日