

Vaccination Guide

予防接種について

~ To Protect Your Infant from Infectious Diseases ~

Yokohama City provides vaccinations in cooperation with the Yokohama Medical Association.

Read this Vaccination Guide and Vaccination Handbook (Yobosesshu-no Shiori) which is distributed at Public Health and Welfare Center thoroughly before taking vaccinations.

Please inquire Public Health and Welfare Centers and/or cooperating medical institutions for vaccinations, if you have questions and concerns about vaccinations.

Taking Vaccinations

予防接種を受けましょう

The resistance (immunity) to infectious diseases that infants inherit from their mothers is naturally lost within a year after birth. It is necessary for infants to develop their own immunity for the prevention against infectious diseases since they lose this natural immunity and vaccinations are beneficial for this purpose. Please protect your infant from infectious diseases by having him/her take vaccinations at the appropriate time.

What are Vaccinations?

予防接種とは

There are a variety of infectious diseases that are caused by viruses, bacteria or other pathogens. The purpose of vaccinations is to make people immune or resistant to infectious diseases by giving a vaccine which is made with dead or harmless versions of the infectious agent. This does not mean, however, that there is a vaccine available for all infectious diseases. We don't have vaccines for some diseases because of the nature of the pathogenic organism. Eight infectious diseases which you can get vaccinations for free are as follows: diphtheria, pertussis, tetanus, polio, measles, rubella, Japanese encephalitis, and tuberculosis (BCG). It is desirable to have your child complete vaccinations before s/he is more frequently exposed to disease spread. You are, therefore, encouraged to have your child take the vaccinations at the recommended age (standard vaccination age).

Before Taking Vaccinations

予防接種を受ける前に

In Yokohama, vaccinations are divided in two types and administered separately: ones available at Public Health and Welfare Centers (Page12) and others administered at Cooperating Medical Institutions for Vaccinations (Page 13). Children should be brought in for vaccinations by a parent or caregiver who is well aware of their health condition. Children should get vaccinations when they feel well. It is important that you are always attentive to your child's health condition, such as physical constitution and physical condition. If you have any concerns, please consult with your physician or a Public Health and Welfare Center before taking vaccinations.

Children cannot take vaccinations in the following cases:

If the child has fever (Approx. over 37.5).

If they are having a serious sudden illness

If the child, in the past, had anaphylactic reaction with the inoculation of the same vaccination.

In case of BCG, if the past vaccinations or injuries have resulted in keloid scar.

In case of BCG, if the child was infected by tuberculosis in the past.

In case of polio vaccination, if the child is seriously diabetic.

In case of live vaccine, if the child has disease which causes malfunctioning in the immunity system or is under treatment which has immunodepressive effect.

In other cases, if the doctor judged if it is inappropriate.

If the child has following diseases, commonly, they should be vaccinated after certain lengths of time:

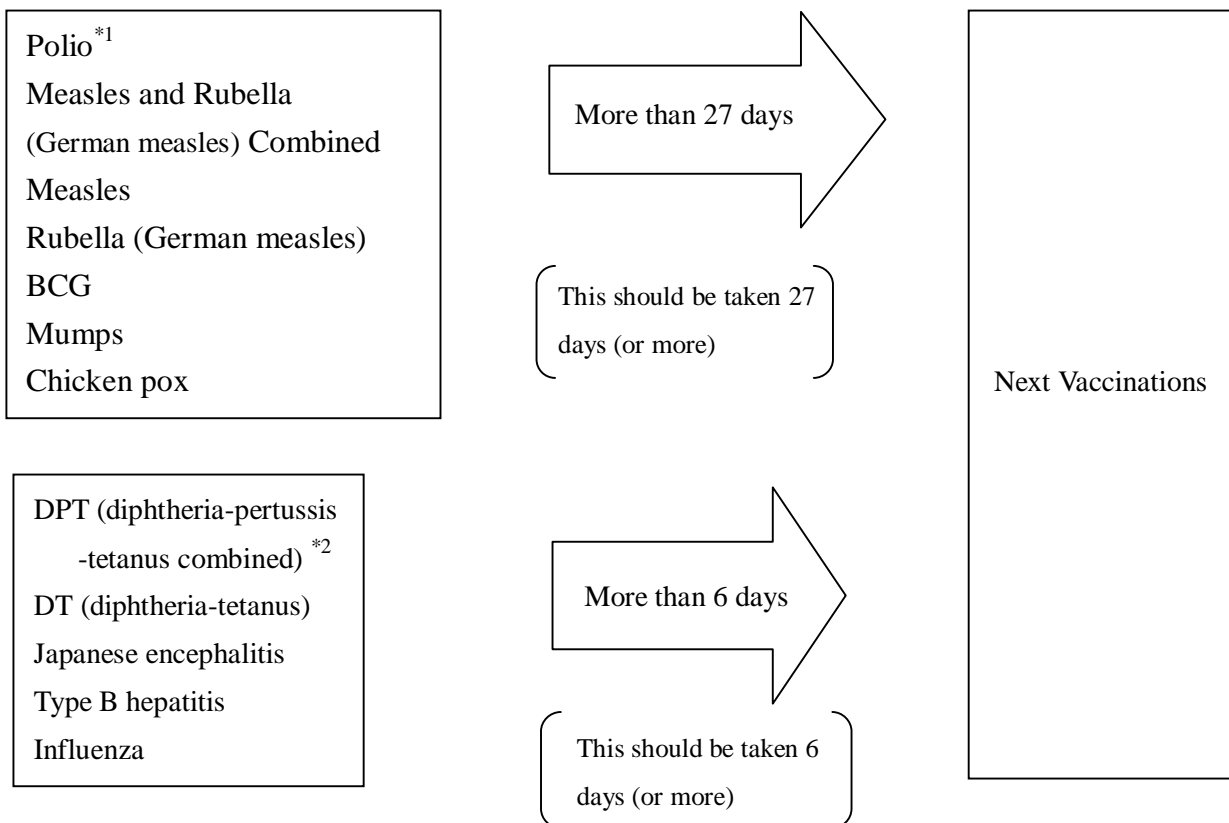
- Measles:2-4 weeks after the disease has been cured
- Rubella, Chicken pox, Mumps:1-2 weeks after the disease has been cured
- Acute rash and hand-foot-and-mouth disease, erythema etc.: 1-2 weeks after the disease has been cured

Intervals between Vaccinations

他の予防接種との間隔

In order to take vaccinations safely and effectively, it is necessary to wait a specific number of days between vaccinations.

Previous vaccinations



* 1 Polio vaccinations are administered twice, usually in April and in October.

* 2 Three doses of DPT vaccinations, Stage I, are given at 20-56 days interval.

* 3 Two doses of Japanese encephalitis vaccinations, Stage I, are given at 6-28 days interval

Cautions following Vaccinations

予防接種後の注意

For 30 minutes after inoculations, you should observe your child at the medical institution, or make sure to be able to get in touch with the doctor. There might be sudden side reactions during this time.

After inoculations, be aware of side reactions. In case of live vaccines (measles/rubella mixed, measles, rubella, polio, BCG), watch for 4 weeks, and in case of inactivated vaccines (DPT, DT, Japanese encephalitis), watch for 1 week.

Inoculation sites should be kept clean. Bathing on the inoculation day is fine, but you should not rub the inoculation site.

Avoid any heavy physical exercises on the inoculation day.

After the inoculation, consult the doctor immediately if any extreme side reactions happen.

◆ Reactions which could happen

Following reactions could sometimes happen after inoculations: You do not have to worry about them, but if such symptoms are very strong, or if there are any abnormal symptoms, consult the doctor immediately, and contact the Health and Welfare Center.

Name of Vaccinations	Major symptoms which could happen after the inoculations
DPT Japanese Encephalitis	Inoculation site may turn red, hurt, or have fever. These symptoms disappear within 2-3 days. After the inoculation of DTP, the inoculation site may turn stiff and become a lump, but it will disappear in 2-3 months. Japanese encephalitis vaccine may cause, once in 700,000-2,000,000 times, ADEM (acute disseminated encephalo myelitis), and if so, within a few days-2 weeks after the inoculation, may result in fever, headache, convulsion, or disorder of movement.
Measles/Rubella	Within 4-14 days after the inoculation, there may be fever, rash, reddening of the inoculation site, nasal drainage, or coughs, but such symptoms usually disappear in a few days.
Polio	It is unlikely that notable symptoms will appear.
BCG	2-3 weeks after the inoculation, there may be a red lump a size of a small bubble, and the top part of it turns yellowish. This will develop into a scab, and will disappear in about 2-3 months.

Vaccinations Administered at Cooperating Medical Institutions for Vaccinations 個別予防接種協力医療機関で受ける予防接種

Vaccine

implementation depends on each local administration.

Type	Recommended age (standard vaccination age)	Number of Times	Period	Valid period (for free vaccinations)
BCG	3 – 5 months after birth	1	Year-round	After birth – 5 months
DPT Diphtheria -Pertussis -Tetanus combined	Stage I Initial vaccination: three times at intervals of 20 - 56 days Weeks in 3 – 12 months after birth	4	Year-round	3 – 89 months after birth
	Stage Additional vaccination: once in 12 – 18 months after initial vaccinations			
Measles and Rubella Combined *1	Stage I 12 – 23 months after birth 1 time Stage 5 or 6 years old or 1 year before entering an elementary school *2 1 time	2	Year-round	Stage I 12 – 23 months after birth Stage During one year before entering elementary school. *2
Japanese encephalitis	Stage I: Initial vaccination: twice at intervals of 6 - 28 days in age 3	3	Year-round (In accordance with the Ministry's advisory, Yokohama has stopped the recommendation for the vaccine but if you wish to receive it we will give it.	6 – 89 months after birth
	Stage I Booster: once in age 4			

*1 Upon request, measles and rubella vaccines can be inoculated separately.

*2 **Stage** : Children from age 5 to 6 can take vaccine anytime between 1st April in one year before their entering elementary school to 31st March in the year of their entering elementary school).

- ◆ These vaccinations are provided by Cooperating Medical Institutions for Vaccinations in Yokohama. If you were to choose your home doctor or the cooperating medical institutions, you are recommended to choose your home doctor.
- ◆ Please inquire about vaccination schedule information and other details in advance at the cooperating medical institution where vaccinations are to be administered.
- ◆ On the day of a vaccination, please take your child's body temperature before leaving home to confirm that it is normal. In addition, be sure to read the Vaccination Handbook (Yobosesshu-no Shiori) carefully and fill in the required information in the Japanese version of Vaccination Questionnaire (Vaccination Coupon) before leaving home and bring it with you to the medical institution without tearing it apart.
- ◆ The leaflet "Vaccination Handbook" (Yobosesshu-no Shiori) is distributed at Public Health and Welfare Centers.
- ◆ Be sure to bring your Mother and Child Health Handbook (Boshi Kenko Techo) so that the vaccination can be recorded on it.
- ◆ Read the "Cautions following Vaccinations" (Sesshugo-no Chui) carefully after the vaccination is administered.
- ◆ Please inquire at the Public Health and Welfare Center or the cooperating medical institution if you have any concerns or difficulties.
- ◆ If you were to choose your home doctor or the cooperating medical institutions, you are recommended to choose your home doctor. Please note that if you miss the age you can get the shots for free, you need to pay for them.

Cupon for vaccination
接種券

Medical Questionnaire for BCG Vaccination

City of Yokohama

BCG 予防接種予診票
(under 6 months of age)Body Temperature at
the venue
診察前(会場)の体温

度 分

Cannot be used in medical institutions outside the city

Address 住所	ku (ward) 区	Telephone No. 電話	
Child's (Recipient's) Name 受ける人の氏名	見本	Male 男	Date of Birth 生年月日
Guardian's Name 保護者の氏名		Female 女	Year Month Day 年 月 日生 Age: ___ Yrs. ___ Months old (満 歳 か月)

QUESTIONS	RESPONSES		PHYSICIAN'S COMMENTS
Have you read the explanation of the Vaccination(Vaccination Guide etc.) being distributed by the City of Yokohama ? 今日受ける予防接種について横浜市から配られている説明書(「予防接種のしおり」など)を読みましたか	Yes はい	No いいえ	
We will ask you about your child's growth. あなたのお子さんの発育歴についておたずねします What was your child's weight at birth? 出生体重 () grams Were there any unusual circumstances during delivery? 分娩時に異常がありましたか Were there any unusual circumstances after childbirth? 出生後に異常がありましたか Were you informed of any extraordinary conditions in your child at the child health examination? 乳児健診で異常があるといわれたことがありますか	Yes あった Yes あった Yes ある	No なかった No なかった No ない	
Do you have any concerns about your child's health now? 今日体に具合の悪いところがありますか If you answered "yes", please write the specific symptoms: () 具体的な症状を書いてください	Yes はい	No いいえ	
Has your child been ill in the past one month? 最近1か月以内に病気にかかりましたか If you answered "yes", please write the name of illness and the date of recovery: () 病名、治ゆ日	Yes はい	No いいえ	
Has your baby been around anyone (such as a family member) who has Tuberculosis? 生まれてから今までに家族など身のまわりに結核にかかった方がいましたか	Yes はい	No いいえ	
Has your child had any vaccination in the past four weeks? 1か月以内に予防接種を受けましたか If you answered "yes", please write the type of vaccination and the date: () 予防接種の種類、接種日	Yes はい	No いいえ	
Has your child ever been diagnosed for any of the following conditions; Congenital disorder, disease of Heart, Kidney, Liver, Brain Nerve, or Immune Deficiency and others? If you answered "yes", please write name of illness: () 生まれてから今までに先天性異常、心臓、腎臓、肝臓、脳神経、免疫不全症、その他の病気にかかり医師の診察を受けていますか 病名	Yes はい	No いいえ	
If your child has been treated for any of the above, has the attending physician approved today's vaccination? その病気を診てもらっている医師に今日の予防接種を受けてよいといわれましたか	Yes はい	No いいえ	
Has your child ever experienced convulsions? ひきつけ(けいれん)をおこしたことがありますか when age: () 歳頃	Yes はい	No いいえ	
If you answered "yes", did the child have a fever at that time? そのときに熱がでましたか	Yes はい	No いいえ	
Have any of your close relatives been diagnosed with a Congenital Immune deficiency? 近親者に先天性免疫不全と診断されている方はいますか	Yes はい	No いいえ	
Has your baby ever become ill from a vaccination? これまでに予防接種を受けて具合が悪くなったことはありますか If yes, what type of vaccination? () 予防接種の種類	Yes はい	No いいえ	
Has anyone of your close relatives ever become ill form a BCG vaccination? 近親者に BCG 接種を受けて具合が悪くなった人はいますか	Yes はい	No いいえ	
Do you have any questions regarding today's vaccination? 今日の BCG 接種について質問がありますか	Yes はい	No いいえ	
Physician's Comments 医師記入欄	Due to the results of the medical examination and the questionnaire, today's inoculation will be (given / postponed). 以上の問診及び診察の結果、今日の予防接種は(可能 ・ 見合わせる) I have explained to the guardians on the effect and reactions of the vaccination as well as the Relief System for Injury to Health with the Vaccination. 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した。 Physician's Signature or Name and Seal 医師署名または記名押印		

Having received a medical examination and explanation by a doctor, would you like to receive an inoculation with the understanding of the effect and the possibility of side reactions? (Yes/No)
医師の診察・説明を受け、予防接種の効果や副反応などについて理解した上で、接種を希望しますか(接種を希望します・接種を希望しません)
This questionnaire is aimed at confirming the safety of the vaccinations.
この予診票は、予防接種の安全性の確保を目的としています。
With understanding of the above, I agree for this questionnaire to be submitted to the municipality in charge.
このことを理解の上、本予診票が市町村に提出されることに同意します。Parent's/Guardian's Signature 保護者自署

Vaccine lot number ワクチンロット番号	Dose 接種量	Medical Institution · Name of Physician · Date 実施場所・医師名・接種年月日
Lot No.	Percutaneous vaccination of the defined amount 規定量を管針にて経皮接種	Medical Institution 実施医療機関 Physician 医師名 Vaccination Date 接種年月日 平成 年 月 日

Cautions After Taking BCG Vaccinations

■After the inoculation, please note:

- 1 For 30 minutes after inoculations, you should observe your child at the medical institution, or make sure to be able to get in touch with the doctor. There might be sudden side reactions during this time.
- 2 For 4 weeks after the inoculation, be aware of the happening of side reactions.
- 3 Inoculation sites should be kept clean. Bathing on the inoculation day is fine, but **you should not rub the inoculation site.**
- 4 After the inoculation, consult the doctor immediately if any extreme side reactions happen.

■Common Reactions and Koch Phenomenon

1 Common reactions

Around 10 days after the inoculation, there will be red spots in the inoculation site, which might contain pus.

This reaction is most strong at around 4 weeks after the inoculation, but it will naturally cure around 3 months after the inoculation. Do not put band-aid, and keep the area clean.

2 Koch Phenomenon

If the child had Tuberculosis in the past, **within 10 days after the inoculation**, the inoculation site may turn red, swell, or the site may mature.

This reaction is called the Koch Phenomenon.

It will naturally cure in about 2-4 weeks, if you keep the inoculation site clean.

However, **if you see any symptoms of the Koch Phenomenon, the child needs to be checked if he/she is infected by TB, so please consult the medical institution which gave the inoculation, or your ward's Health and Welfare Center.**

■Side Reaction of BCG inoculations

Within about 1 month after the inoculation, the lymph nodes in the armpit which had the shot, may be enlarged. It will cure naturally, but if that area becomes sore, swell, or mature and discharges pus, then please consult your doctor.

■Time until the next vaccination

After the BCG vaccination, leave more than 27 days until you take any other vaccinations.

Coupon for Stage I Initial vaccination-1
接種券 1期初回-1

Medical Questionnaire for DPT Vaccination [Diphtheria, Pertussis, Tetanus]

三種混合予防接種予診票 [ジフテリア・百日せき・破傷風]

City of Yokohama

(3-89 months after birth)

(生後 3 か月 ~ 90 か月 [7 歳 6 か月] 未満)

Body Temperature at
the venue
診察前(会場)の体温

度 分

Cannot be used in medical institutions outside the city

Address 住所	ku (ward) 区	Telephone No. 電話	
Child's (Recipient's) Name 受ける人の氏名	見本	Male 男	Date of Birth 生年月日
Guardian's Name 保護者の氏名		Female 女	Year Month Day 年 月 日生 Age: ___ Yrs. ___ Months old (満 歳 か月)

QUESTIONS	RESPONSES		PHYSICIAN'S COMMENTS
Have you read the explanation of the Vaccination(Vaccination Guide etc.) being distributed by the City of Yokohama? 今日受ける予防接種について横浜市から配られている説明書(「予防接種のしおり」など)を読みましたか	Yes はい	No いいえ	
We will ask you about your child's growth. あなたのお子さんの発育歴についておたずねします What was your child's weight at birth? 出生体重 () grams Were there any unusual circumstances during delivery? 分娩時に異常がありましたか Were there any unusual circumstances after childbirth? 出生後に異常がありましたか Were you informed of any extraordinary conditions in your child at the child health examination? 乳児健診で異常があるといわれたことがありますか	Yes あった Yes あった Yes ある	No なかった No なかった No ない	
Do you have any concerns about your child's health now? 今日体に具合の悪いところがありますか If you answered "yes", please write the specific symptoms: () 具体的な症状を書いてください	Yes はい	No いいえ	
Has your child been ill in the past one month? 最近 1 か月以内に病気にかかりましたか If you answered "yes", please write the name of illness and the date of recovery: () 病名、治ゆ日	Yes はい	No いいえ	
Has your baby been around anyone (such as a family member) who has Tuberculosis? 生まれてから今までに家族など身のまわりに結核にかかった方がいましたか	Yes はい	No いいえ	
Has your child had any vaccination in the past four weeks? 1 か月以内に予防接種を受けましたか If you answered "yes", please write the type of vaccination and the date: () 予防接種の種類、接種日	Yes はい	No いいえ	
Has your child ever been diagnosed for any of the following conditions; Congenital disorder, disease of Heart, Kidney, Liver, Brain Nerve, or Immune Deficiency and others? If you answered "yes", please write name of illness: () 生まれてから今までに先天性異常、心臓、腎臓、肝臓、脳神経、免疫不全症、その他の病気にかかり医師の診察を受けていますか 病名	Yes はい	No いいえ	
If your child has been treated for any of the above, has the attending physician approved today's vaccination? その病気を診てもらっている医師に今日の予防接種を受けてよいといわれましたか	Yes はい	No いいえ	
Has your child ever experienced convulsions? ひきつけ(けいれん)をおこしたことがありますか when age: () 歳頃	Yes はい	No いいえ	
If you answered "yes", did the child have a fever at that time? そのときに熱がでましたか	Yes はい	No いいえ	
Have any of your close relatives been diagnosed with a Congenital Immune deficiency? 近親者に先天性免疫不全と診断されている方はいますか	Yes はい	No いいえ	
Has your baby ever become ill from a vaccination? これまでに予防接種を受けて具合が悪くなったことはありますか If yes, what type of vaccination? () 予防接種の種類	Yes はい	No いいえ	
Has your child had a blood transfusion or Gamma Globulin injection, in the last six months? 6 か月以内に輸血あるいはガンマグロブリンの注射を受けましたか	Yes はい	No いいえ	
Do you have any questions regarding today's vaccination? 今日の予防接種について質問がありますか	Yes はい	No いいえ	
Physician's Comments 医師記入欄: Based on the above and the examination, today's vaccination is to be (conducted, withheld) 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 ・ 見合わせた方がよい) と判断します。 I have explained to the guardians on the effect and reactions of the vaccination as well as the Relief System for Injury to Health with the Vaccination. Physician's Signature or Name and Seal 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、説明しました。 医師署名または記名押印			

Having received a medical examination and explanation by a doctor, would you like to receive an inoculation with the understanding of the effect, the possibility of side reactions and the Relief System for Injury to Health with Vaccinations? (Yes / No) Please circle either yes or no in parenthesis.
医師の診察・説明を受け、予防接種の効果や目的、重篤な副反応の可能性、予防接種健康被害救済制度などについて理解した上で、接種することに (同意します・同意しません) カッコの中のどちらかを で囲んでください。
This questionnaire is intended to ensure the safety of vaccinations. I understand it and consent that this questionnaire will be sent to a municipal office. Parent's/Guardian's Signature
この予診票は、予防接種の安全性の確保を目的としています。このことを理解の上、本予診票が市町村に提出されることに同意します。保護者自署

Vaccine Name 使用ワクチン名	Dose 接種量	Medical Institution · Name of Physician · Date 実施場所・医師名・接種年月日
Vaccine Name ワクチン名	(hypodermic injection) (皮下接種)	Medical Institution 実施医療機関 Physician 医師名 Vaccination Date 接種年月日
Lot No.	ml	Year Month Day 平成 年 月 日

-globulin is a type of blood product injected to prevent infectious diseases such as type A hepatitis and to treat serious infectious diseases.
For a three to six month interval following use, -globulin medication may weaken the effects of the measles vaccination.

Coupon for Stage I Initial vaccination-2
接種券 1期初回-2

Medical Questionnaire for DPT Vaccination (Diphtheria, Pertussis, Tetanus)

三種混合予防接種予診票 (ジフテリア・百日せき・破傷風)

City of Yokohama

(3-89 months after birth)

(生後3か月~90か月[7歳6か月]未満)

Body Temperature at
the venue
診察前(会場)の体温

度 分

Cannot be used in medical institutions outside the city

Address 住所	ku (ward) 区	Telephone No. 電話	
Child's (Recipient's) Name 受ける人の氏名	見本	Male 男	Date of Birth 生年月日
Guardian's Name 保護者の氏名		Female 女	Year Month Day 年 月 日生 Age: ___ Yrs. ___ Months old (満 歳 か月)

QUESTIONS	RESPONSES		PHYSICIAN'S COMMENTS
	Yes はい	No いいえ	
Have you read the explanation of the Vaccination (Vaccination Guide etc.) being distributed by the City of Yokohama? 今日受ける予防接種について横浜市から配られている説明書(「予防接種のしおり」など)を読みましたか	Yes はい	No いいえ	
We will ask you about your child's growth. あなたのお子さんの発育歴についておたずねします What was your child's weight at birth? 出生体重 () grams Were there any unusual circumstances during delivery? 分娩時に異常がありましたか Were there any unusual circumstances after childbirth? 出生後に異常がありましたか Were you informed of any extraordinary conditions in your child at the child health examination? 乳児健診で異常があるといわれたことがありますか	Yes あった Yes あった Yes ある	No なかった No なかった No ない	
Do you have any concerns about your child's health now? 今日体に具合の悪いところがありますか If you answered "yes", please write the specific symptoms: () 具体的な症状を書いてください	Yes はい	No いいえ	
Has your child been ill in the past one month? 最近1か月以内に病気にかかりましたか If you answered "yes", please write the name of illness and the date of recovery: () 病名、治ゆ日	Yes はい	No いいえ	
Has your baby been around anyone (such as a family member) who has Tuberculosis? 生まれてから今までに家族など身のまわりに結核にかかった方がいましたか	Yes はい	No いいえ	
Has your child had any vaccination in the past four weeks? 1か月以内に予防接種を受けましたか If you answered "yes", please write the type of vaccination and the date: () 予防接種の種類、接種日	Yes はい	No いいえ	
Has your child ever been diagnosed for any of the following conditions; Congenital disorder, disease of Heart, Kidney, Liver, Brain Nerve, or Immune Deficiency and others? If you answered "yes", please write name of illness: () 生まれてから今までに先天性異常、心臓、腎臓、肝臓、脳神経、免疫不全症、その他の病気にかかり医師の診察を受けていますか 病名	Yes はい	No いいえ	
If your child has been treated for any of the above, has the attending physician approved today's vaccination? その病気を診てもらっている医師に今日の予防接種を受けてよいといわれましたか	Yes はい	No いいえ	
Has your child ever experienced convulsions? ひきつけ(けいれん)をおこしたことがありますか 歳頃 when age: ()	Yes はい	No いいえ	
If you answered "yes", did the child have a fever at that time? そのときに熱がでましたか	Yes はい	No いいえ	
Have any of your close relatives been diagnosed with a Congenital Immune deficiency? 近親者に先天性免疫不全と診断されている方はいますか	Yes はい	No いいえ	
Has your baby ever become ill from a vaccination? これまでに予防接種を受けて具合が悪くなったことはありますか If yes, what type of vaccination? () 予防接種の種類	Yes はい	No いいえ	
Has your child had a blood transfusion or Gamma Globulin injection, in the last six months? 6か月以内に輸血あるいはガンマグロブリンの注射を受けましたか	Yes はい	No いいえ	
Do you have any questions regarding today's vaccination? 今日の予防接種について質問がありますか	Yes はい	No いいえ	
Physician's Comments 医師記入欄: Based on the above and the examination, today's vaccination is to be (conducted, withheld) 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・見合わせた方がよい)と判断します。 I have explained to the guardians on the effect and reactions of the vaccination as well as the Relief System for Injury to Health with the Vaccination. Physician's Signature or Name and Seal 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、説明しました。 医師署名または記名押印			

Having received a medical examination and explanation by a doctor, would you like to receive an inoculation with the understanding of the effect, the possibility of side reactions and the Relief System for Injury to Health with Vaccinations? (Yes / No) Please circle either yes or no in parenthesis.
医師の診察・説明を受け、予防接種の効果や目的、重篤な副反応の可能性、予防接種健康被害救済制度などについて理解した上で、接種することに(同意します・同意しません) カッコの中のどちらかを で囲んでください。
This questionnaire is intended to ensure the safety of vaccinations. I understand it and consent that this questionnaire will be sent to a municipal office. Parent's/Guardian's Signature
この予診票は、予防接種の安全性の確保を目的としています。このことを理解の上、本予診票が市町村に提出されることに同意します。保護者自署

Vaccine Name 使用ワクチン名	Dose 接種量	Medical Institution · Name of Physician · Date 実施場所・医師名・接種年月日
Vaccine Name ワクチン名	(hypodermic injection) (皮下接種)	Medical Institution 実施医療機関 Physician 医師名 Vaccination Date 接種年月日
Lot No.	ml	Year Month Day 平成 年 月 日

-globulin is a type of blood product injected to prevent infectious diseases such as type A hepatitis and to treat serious infectious diseases.
For a three to six month interval following use, -globulin medication may weaken the effects of the measles vaccination.

Coupon for Stage I Initial vaccination-1
接種券1期初回-3

Medical Questionnaire for DPT Vaccination [Diphtheria, Pertussis, Tetanus]

三種混合予防接種予診票 [ジフテリア・百日せき・破傷風]

City of Yokohama

(3-89 months after birth)
(生後3か月~90か月[7歳6か月]未満)

Cannot be used in medical institutions outside the city

Body Temperature at the venue 診察前(会場)の体温	度 分
Address 住所	ku (ward) 区
Telephone No. 電話	
Child's (Recipient's) Name 受ける人の氏名	見本
Guardian's Name 保護者の氏名	
Male 男	Female 女
Date of Birth 生年月日	Year 年 Month 月 Day 日 Age: ___ Yrs. ___ Months old (満 歳 か月)

QUESTIONS	RESPONSES		PHYSICIAN'S COMMENTS
Have you read the explanation of the Vaccination(Vaccination Guide etc.) being distributed by the City of Yokohama ? 今日受ける予防接種について横浜市から配られている説明書(「予防接種のしおり」など)を読みましたか	Yes はい	No いいえ	
We will ask you about your child's growth. あなたのお子さんの発育歴についておたずねします What was your child's weight at birth? 出生体重 () grams Were there any unusual circumstances during delivery? 分娩時に異常がありましたか Were there any unusual circumstances after childbirth? 出生後に異常がありましたか Were you informed of any extraordinary conditions in your child at the child health examination? 乳児健診で異常があるといわれたことがありますか	Yes あった Yes あった Yes ある	No なかった No なかった No ない	
Do you have any concerns about your child's health now? 今日体に具合の悪いところがありますか If you answered "yes", please write the specific symptoms: () 具体的な症状を書いてください	Yes はい	No いいえ	
Has your child been ill in the past one month? 最近1か月以内に病気がかかりましたか If you answered "yes", please write the name of illness and the date of recovery: () 病名、治ゆ日	Yes はい	No いいえ	
Has your baby been around anyone (such as a family member) who has Tuberculosis? 生まれてから今までに家族など身のまわりに結核にかかった方がいましたか	Yes はい	No いいえ	
Has your child had any vaccination in the past four weeks? 1か月以内に予防接種を受けましたか If you answered "yes", please write the type of vaccination and the date: () 予防接種の種類、接種日	Yes はい	No いいえ	
Has your child ever been diagnosed for any of the following conditions: Congenital disorder, disease of Heart, Kidney, Liver, Brain Nerve, or Immune Deficiency and others? If you answered "yes", please write name of illness: () 生まれてから今までに先天性異常、心臓、腎臓、肝臓、脳神経、免疫不全症、その他の病気にかかり医師の診察を受けていますか 病名	Yes はい	No いいえ	
If your child has been treated for any of the above, has the attending physician approved today's vaccination? その病気を診てもらっている医師に今日の予防接種を受けてよいといわれましたか	Yes はい	No いいえ	
Has your child ever experienced convulsions? ひきつけ(けいれん)をおこしたことがありますか when age: () 歳頃	Yes はい	No いいえ	
If you answered "yes", did the child have a fever at that time? そのときに熱がでましたか	Yes はい	No いいえ	
Have any of your close relatives been diagnosed with a Congenital Immune deficiency? 近親者に先天性免疫不全と診断されている方はいますか	Yes はい	No いいえ	
Has your baby ever become ill from a vaccination? これまでに予防接種を受けて具合が悪くなったことはありますか If yes, what type of vaccination? () 予防接種の種類	Yes はい	No いいえ	
Has your child had a blood transfusion or Gamma Globulin injection, in the last six months? 6か月以内に輸血あるいはガンマグロブリンの注射を受けましたか	Yes はい	No いいえ	
Do you have any questions regarding today's vaccination? 今日の予防接種について質問がありますか	Yes はい	No いいえ	

Physician's Comments 医師記入欄:
Based on the above and the examination, today's vaccination is to be (conducted, withheld)
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 ・ 見合わせた方がよい) と判断します。
I have explained to the guardians on the effect and reactions of the vaccination as well as the Relief System for Injury to Health with the Vaccination. Physician's Signature or Name and Seal
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、説明しました。 医師署名または記名押印

Having received a medical examination and explanation by a doctor, would you like to receive an inoculation with the understanding of the effect, the possibility of side reactions and the Relief System for Injury to Health with Vaccinations? (Yes / No) Please circle either yes or no in parenthesis.
医師の診察・説明を受け、予防接種の効果や目的、重篤な副反応の可能性、予防接種健康被害救済制度などについて理解した上で、接種することに (同意します ・ 同意しません) カッコの中のどちらかを で囲んでください。
This questionnaire is intended to ensure the safety of vaccinations. I understand it and consent that this questionnaire will be sent to a municipal office. Parent's/Guardian's Signature
この予診票は、予防接種の安全性の確保を目的としています。このことを理解の上、本予診票が市町村に提出されることに同意します。保護者自署

Vaccine Name 使用ワクチン名	Dose 接種量	Medical Institution · Name of Physician · Date 実施場所・医師名・接種年月日
Vaccine Name ワクチン名	(hypodermic injection) (皮下接種)	Medical Institution 実施医療機関 Physician 医師名 Vaccination Date 接種年月日
Lot No.	ml	Year 年 Month 月 Day 日 平成 年 月 日

-globulin is a type of blood product injected to prevent infectious diseases such as type A hepatitis and to treat serious infectious diseases.
For a three to six month interval following use, -globulin medication may weaken the effects of the measles vaccination.

Coupon for Stage I Additional vaccination
接種券 I 期追加

Medical Questionnaire for DPT Vaccination (Diphtheria, Pertussis, Tetanus)

三種混合予防接種予診票 (ジフテリア・百日せき・破傷風)

City of Yokohama

(3-89 months after birth)

(生後 3 か月 ~ 90 か月 [7 歳 6 か月] 未満)

Body Temperature at
the venue
診察前(会場)の体温

度 分

Cannot be used in medical institutions outside the city

Address 住所	ku (ward) 区	Telephone No. 電話	
Child's (Recipient's) Name 受ける人の氏名	見本	Male 男	Date of Birth 生年月日
Guardian's Name 保護者の氏名		Female 女	Year Month Day 年 月 日生 Age: ___ Yrs. ___ Months old (満 歳 か月)

QUESTIONS	RESPONSES		PHYSICIAN'S COMMENTS
Have you read the explanation of the Vaccination(Vaccination Guide etc.) being distributed by the City of Yokohama? 今日受ける予防接種について横浜市から配られている説明書(「予防接種のしおり」など)を読みましたか	Yes はい	No いいえ	
We will ask you about your child's growth. あなたのお子さんの発育歴についておたずねします What was your child's weight at birth? 出生体重 () grams Were there any unusual circumstances during delivery? 分娩時に異常がありましたか Were there any unusual circumstances after childbirth? 出生後に異常がありましたか Were you informed of any extraordinary conditions in your child at the child health examination? 乳児健診で異常があるといわれたことがありますか	Yes あった Yes あった Yes ある	No なかった No なかった No ない	
Do you have any concerns about your child's health now? 今日体に具合の悪いところがありますか If you answered "yes", please write the specific symptoms: () 具体的な症状を書いてください	Yes はい	No いいえ	
Has your child been ill in the past one month? 最近 1 か月以内に病気がかかりましたか If you answered "yes", please write the name of illness and the date of recovery: () 病名、治ゆ日	Yes はい	No いいえ	
Has your baby been around anyone (such as a family member) who has Tuberculosis? 生まれてから今までに家族など身のまわりに結核にかかった方がいましたか	Yes はい	No いいえ	
Has your child had any vaccination in the past four weeks? 1 か月以内に予防接種を受けましたか If you answered "yes", please write the type of vaccination and the date: () 予防接種の種類、接種日	Yes はい	No いいえ	
Has your child ever been diagnosed for any of the following conditions; Congenital disorder, disease of Heart, Kidney, Liver, Brain Nerve, or Immune Deficiency and others? If you answered "yes", please write name of illness: () 生まれてから今までに先天性異常、心臓、腎臓、肝臓、脳神経、免疫不全症、その他の病気にかかり医師の診察を受けていますか 病名	Yes はい	No いいえ	
If your child has been treated for any of the above, has the attending physician approved today's vaccination? その病気を診てもらっている医師に今日の予防接種を受けてよいといわれましたか	Yes はい	No いいえ	
Has your child ever experienced convulsions? ひきつけ(けいれん)をおこしたことがありますか when age: () 歳頃	Yes はい	No いいえ	
If you answered "yes", did the child have a fever at that time? そのときに熱がでましたか	Yes はい	No いいえ	
Have any of your close relatives been diagnosed with a Congenital Immune deficiency? 近親者に先天性免疫不全と診断されている方はいますか	Yes はい	No いいえ	
Has your baby ever become ill from a vaccination? これまでに予防接種を受けて具合が悪くなったことはありますか If yes, what type of vaccination? () 予防接種の種類	Yes はい	No いいえ	
Has your child had a blood transfusion or Gamma Globulin injection, in the last six months? 6 か月以内に輸血あるいはガンマグロブリンの注射を受けましたか	Yes はい	No いいえ	
Do you have any questions regarding today's vaccination? 今日の予防接種について質問がありますか	Yes はい	No いいえ	
Physician's Comments 医師記入欄: Based on the above and the examination, today's vaccination is to be (conducted, withheld) 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・見合わせた方がよい) と判断します。 I have explained to the guardians on the effect and reactions of the vaccination as well as the Relief System for Injury to Health with the Vaccination. Physician's Signature or Name and Seal 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、説明しました。 医師署名または記名押印			

Having received a medical examination and explanation by a doctor, would you like to receive an inoculation with the understanding of the effect, the possibility of side reactions and the Relief System for Injury to Health with Vaccinations? (Yes / No) Please circle either yes or no in parenthesis.
医師の診察・説明を受け、予防接種の効果や目的、重篤な副反応の可能性、予防接種健康被害救済制度などについて理解した上で、接種することに (同意します・同意しません) カッコの中のどちらかを で囲んでください。
This questionnaire is intended to ensure the safety of vaccinations. I understand it and consent that this questionnaire will be sent to a municipal office. Parent's/Guardian's Signature
この予診票は、予防接種の安全性の確保を目的としています。このことを理解の上、本予診票が市町村に提出されることに同意します。保護者自署

Vaccine Name 使用ワクチン名	Dose 接種量	Medical Institution · Name of Physician · Date 実施場所・医師名・接種年月日
Vaccine Name ワクチン名	(hypodermic injection) (皮下接種)	Medical Institution 実施医療機関 Physician 医師名 Vaccination Date 接種年月日
Lot No.	ml	平成 Year Month Day 年 月 日

-globulin is a type of blood product injected to prevent infectious diseases such as type A hepatitis and to treat serious infectious diseases.
For a three to six month interval following use, -globulin medication may weaken the effects of the measles vaccination.

Medical Questionnaire for Combined Vaccination against Measles and Rubella (Stage I)
麻しん【はしか】風しん混合 (MR) 予防接種予診票 (I期用) City of Yokohama
(12-23 months after birth)

Cannot be used in medical institutions outside the city (生後 12 か月 ~ 24 か月未満)		Body Temperature 診察前の体温	度 分
Address 住所	ku (ward) 区	Telephone Number 電話	
Child's (Recipient's) Name 受ける人の氏名	見本	Male 男	Date of Birth 生年月日
Parent's/Guardian's Name 保護者の氏名		Female 女	Year Month Day 年 月 日生 Age: Yrs. Months old (満 歳 か月)

QUESTIONS	RESPONSES		PHYSICIAN'S COMMENTS
Have you read the explanation about today's vaccination (such as Vaccination Guide) distributed by local government? 今日受ける予防接種について市町村から配られている説明書(「予防接種のしおり」など)を読みましたか	Yes はい	No いいえ	
We will ask you about your child's growth. あなたのお子さんの発育歴についておたずねします What was your child's weight at birth? 出生体重 () grams Were there any unusual circumstances during delivery? 分娩時に異常がありましたか Were there any unusual circumstances after childbirth? 出生後に異常がありましたか Were you informed of any extraordinary conditions in your child at the child health examinations? 乳児健診で異常があるといわれたことがありますか	Yes あった Yes あった Yes ある	No なかった No なかった No ない	
Do you have any concerns about your child's health now? 今日体に具合の悪いところがありますか If you answered "yes", please write the specific symptoms: () 具体的な症状を書いてください	Yes はい	No いいえ	
Has your child been ill in the past one month? 最近 1 か月以内に病気にかかりましたか If you answered "yes", please write the name of illness and the date of recovery: () 病名 治ゆ日	Yes はい	No いいえ	
In the past one month, has your child been in contact with any person who has any of the following: Measles, Rubella, Chicken Pox and Mumps, etc? 1 か月以内に家族や遊び仲間に麻しん、風しん、水痘、おたふくかぜなどの病気の方がいましたか If you answered "yes", please write the name of illness: () 病名	Yes はい	No いいえ	
Has your child had any vaccination in the past one month? 1 か月以内に予防接種を受けましたか If you answered "yes", please write the type of vaccination and the date: () 予防接種の種類、接種日	Yes はい	No いいえ	
Has your child ever been diagnosed for any of the following conditions; Congenital disorder, disease of Heart, Kidney, Liver, Brain Nerve, Immune Deficiency, and others? If you answered "yes", please write the name of illness: () 生まれてから今までに先天性異常、心臓、腎臓、肝臓、脳神経、免疫不全症、その他の病気にかかり医師の診察を受けていますか 病名	Yes はい	No いいえ	
If your child has been treated for any of the above, has the attending physician approved today's vaccination? その病気を診てもらっている医師に今日の予防接種を受けてよいといわれましたか	Yes はい	No いいえ	
Has your child ever experienced convulsions? ひきつけ(けいれん)をおこしたことがありますか 歳頃 If you answered "yes", did the child have a fever at that time? そのときに熱がでましたか	Yes はい Yes はい	No いいえ No いいえ	
Has your child ever developed a Rash, Hives or had any other reaction to medicine or food? 薬や食品で皮膚に発疹やじんましんが出たり、体の具合が悪くなったことがありますか	Yes はい	No いいえ	
Have any of your close relatives been diagnosed with a Congenital Immune Deficiency? 近親者に先天性免疫不全と診断されている方はいますか	Yes はい	No いいえ	
Has your child ever become ill from a vaccination? これまでに予防接種を受けて具合が悪くなったことがありますか If yes, what type of vaccination? () 予防接種の種類	Yes ある	No ない	
Has anyone of your close relatives ever become ill from a vaccination? 近親者に予防接種を受けて具合が悪くなった人はいますか	Yes はい	No いいえ	
Has your child had a blood transfusion or Gamma Globulin injection in the last six months? 6 か月以内に輸血あるいはガンマグロブリンの注射を受けましたか	Yes はい	No いいえ	
Do you have any questions regarding today's vaccination? 今日の予防接種について質問がありますか	Yes はい	No いいえ	

Physician's Comments 医師記入欄:
Based on the above and the examination, today's vaccination is to be (conducted, withheld)
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 ・ 見合わせた方がよい) と判断します。
I have explained to the guardians on the effect and reactions of the vaccination as well as the Relief System for Injury to Health with the Vaccination. Physician's Signature or Name and Seal
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、説明しました。 医師署名または記名押印

Having received a medical examination and explanation by a doctor, would you like to receive an inoculation with the understanding of the effect, the possibility of side reactions and the Relief System for Injury to Health with Vaccinations? (Yes / No) Please circle either yes or no in parenthesis.
医師の診察・説明を受け、予防接種の効果や目的、重篤な副反応の可能性、予防接種健康被害救済制度などについて理解した上で、接種することに (同意します ・ 同意しません) カッコの中のとどちらかを で囲んでください。
This questionnaire is intended to ensure the safety of vaccinations. I understand it and consent that this questionnaire will be sent to a municipal office. Parent's/Guardian's Signature
この予診票は、予防接種の安全性の確保を目的としています。このことを理解の上、本予診票が市町村に提出されることに同意します。保護者自署

Vaccine Name	Dosage	Medical Institution · Name of Physician · Date
Vaccine Name ワクチン名	(hypodermic injection) (皮下接種)	Medical Institution 実施医療機関 Physician 医師名 Vaccination Date 接種年月日
Lot No.	ml	Year Month Day 平成 年 月 日

-globulin is a type of blood product injected to prevent infectious diseases such as type A hepatitis and to treat serious infectious diseases. For a three to six month interval following use, -globulin medication may weaken the effects of the measles vaccination.

Medical Questionnaire for Combined Vaccination against Measles and Rubella (Stage)

麻疹【はしか】風しん混合 (MR) 予防接種予診票 (期用)

(From 1st April in one year before children entering elementary school to 31st March in the year of their entering elementary school: 5 years old to 6 years old)
(5歳～7歳未満で、小学校に入学する1年前の4月1日～小学校に入学する年の3月31日までの間にあるもの) **City of Yokohama**

Cannot be used in medical institutions outside the city		Body Temperature 診察前の体温	度 分			
Address 住所	ku (ward) 区	Telephone Number 電話				
Child's (Recipient's) Name 受ける人の氏名	見本	Male 男	Date of Birth 生年月日	Year 年	Month 月	Day 日生
Parent's/Guardian's Name 保護者の氏名		Female 女	Age: (満)	Yrs. 歳	Months old か月)	

QUESTIONS	RESPONSES		PHYSICIAN'S COMMENTS
Have you read the explanation about today's vaccination (such as Vaccination Guide) distributed by local government? 今日受ける予防接種について市町村から配られている説明書(「予防接種のしおり」など)を読みましたか	Yes はい	No いいえ	
We will ask you about your child's growth. あなたのお子さんの発育歴についておたずねします What was your child's weight at birth? 出生体重 () grams Were there any unusual circumstances during delivery? 分娩時に異常がありましたか Were there any unusual circumstances after childbirth? 出生後に異常がありましたか Were you informed of any extraordinary conditions in your child at the child health examinations? 乳児健診で異常があるといわれたことがありますか	Yes はい	No いいえ	
Do you have any concerns about your child's health now? 今日体に具合の悪いところがありますか If you answered "yes", please write the specific symptoms () 具体的な症状を書いてください	Yes はい	No いいえ	
Has your child been ill in the past one month? 最近1か月以内に病気にかかりましたか If you answered "yes", please write the name of illness and the date of recovery: () 病名、治ゆ日	Yes はい	No いいえ	
In the past one month, has your child been in contact with any person who has any of the following: Measles, Rubella, Chicken Pox and Mumps, etc.,? 1か月以内に家族や遊び仲間に麻疹、風しん、水痘、おたふくかぜなどの病気の方がいましたか If you answered "yes", please write the name of illness: () 病名	Yes はい	No いいえ	
Has your child had any vaccination in the past one month? 1か月以内に予防接種を受けましたか If you answered "yes", please write the type of vaccination and the date: () 予防接種の種類、接種日	Yes はい	No いいえ	
Has your child ever been diagnosed for any of the following conditions; Congenital disorder, disease of Heart, Kidney, Liver, Brain Nerve, Immune Deficiency, and others? If you answered "yes", please write the name of illness: () 生まれてから今までに先天性異常、心臓、腎臓、肝臓、脳神経、免疫不全症、その他の病気にかかり医師の診察を受けていますか、病名	Yes はい	No いいえ	
If your child has been treated for any of the above, has the attending physician approved today's vaccination? その病気を診てもらっている医師に今日の予防接種を受けてよいといわれましたか	Yes はい	No いいえ	
Has your child ever experienced convulsions? ひきつけ(けいれん)をおこしたことがありますか when age: () 歳頃	Yes はい	No いいえ	
If you answered "yes", did the child have a fever at that time? そのときに熱がでましたか	Yes はい	No いいえ	
Has your child ever developed a Rash, Hives or had any other reaction to medicine or food? 薬や食品で皮膚に発疹やじんましんが出たり、体の具合が悪くなったことがありますか	Yes はい	No いいえ	
Have any of your close relatives been diagnosed with a Congenital Immune Deficiency? 近親者に先天性免疫不全と診断されている方はいますか	Yes はい	No いいえ	
Has your child ever become ill from a vaccination? これまでに予防接種を受けて具合が悪くなったことがありますか If yes, what type of vaccination? () 予防接種の種類	Yes はい	No いいえ	
Has anyone of your close relatives ever become ill from a vaccination? 近親者に予防接種を受けて具合が悪くなった人はいますか	Yes はい	No いいえ	
Has your child had a blood transfusion or Gamma Globulin injection in the last six months? 6か月以内に輸血あるいはガンマグロブリンの注射を受けましたか	Yes はい	No いいえ	
Do you have any questions regarding today's vaccination? 今日の予防接種について質問がありますか	Yes はい	No いいえ	

Physician's Comments 医師記入欄:
Based on the above and the examination, today's vaccination is to be (conducted, withheld)
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 ・ 見合わせた方がよい) と判断します。
I have explained to the guardians on the effect and reactions of the vaccination as well as the Relief System for Injury to Health with the Vaccination.
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、説明しました。 Physician's Signature or Name and Seal
医師署名名又は記名押印

Having received a medical examination and explanation by a doctor, would you like to receive an inoculation with the understanding of the effect, the possibility of side reactions and the Relief System for Injury to Health with Vaccinations? (Yes/No) Please circle either yes or no in parenthesis.
医師の診察・説明を受け、予防接種の効果や目的、重篤な副反応の可能性、予防接種健康被害救済制度などについて理解した上で、接種することに (同意します ・ 同意しません) カッコの中のどちらかを 囲んでください。
This questionnaire is intended to ensure the safety of vaccinations. I understand it and consent that this questionnaire will be sent to a municipal office. Parent's/Guardian's Signature
この予診票は、予防接種の安全性の確保を目的としています。このことを理解の上、本予診票が市町村に提出されることに同意します。保護者自署

Vaccine Name	Dosage	Medical Institution · Name of Physician · Date
Vaccine Name ワクチン名	(hypodermic injection) (皮下接種)	Medical Institution 実施医療機関 Physician 医師名 Vaccination Date 接種年月日
Lot No.	ml	平成 Year 年 Month 月 Day 日

-globulin is a type of blood product injected to prevent infectious diseases such as type A hepatitis and to treat serious infectious diseases. For a three to six month interval following use, -globulin medication may weaken the effects of the measles vaccination.

Medical Questionnaire for Japanese Encephalitis Vaccination

日本脳炎予防接種予診票

(6-89 months after birth)

(生後 6 か月 ~ 90 か月 [7 歳 6 か月] 未満)

Cannot be used in medical institutions outside the city

Address 住所		ku (ward) 区	Body Temperature 診察前の体温	度 分	
Child's (Recipient's) Name 受ける人の氏名		見本	Telephone Number 電話		
Parent's/Guardian's Name 保護者の氏名			Male 男 Female 女	Date of Birth 生年月日	Year 年 (満 歳)

QUESTIONS	RESPONSES		PHYSICIAN'S COMMENTS
Have you read the explanation about today's vaccination (such as Vaccination Guide) distributed by local government? 今日受ける予防接種について市町村から配られている説明書(「予防接種のしおり」など)を読みましたか	Yes はい	No いいえ	
We will ask you about your child's growth. あなたのお子さんの発育歴についておたずねします What was your child's weight at birth? 出生体重 () grams Were there any unusual circumstances during delivery? 分娩時に異常がありましたか Were there any unusual circumstances after childbirth? 出生後に異常がありましたか Were you informed of any extraordinary conditions in your child at the child health examinations? 乳児健診で異常があるといわれたことがありますか	Yes あった Yes あった Yes ある	No なかった No なかった No ない	
Do you have any concerns about your child's health now? 今日体に具合の悪いところがありますか If you answered "yes", please write the specific symptoms: () 具体的な症状を書いてください	Yes はい	No いいえ	
Has your child been ill in the past one month? 最近 1 か月以内に病気にかかりましたか If you answered "yes", please write the name of illness and the date of recovery: () 病名・治り日	Yes はい	No いいえ	
In the past one month, has your child been in contact with any person who has any of the following: Measles, Rubella, Chicken Pox and Mumps, etc? 1 か月以内に家族や遊び仲間に麻疹、風しん、水痘、おたふくかぜなどの病気の方がいましたか If you answered "yes", please write the name of illness: () 病名	Yes はい	No いいえ	
Has your child had any vaccination in the past one month? 1 か月以内に予防接種を受けましたか If you answered "yes", please write the type of vaccination and the date: () 予防接種の種類、接種日	Yes はい	No いいえ	
Has your child ever been diagnosed for any of the following conditions; Congenital disorder, disease of Heart, Kidney, Liver, Brain Nerve, Immune Deficiency, and others? If you answered "yes", please write the name of illness: () 生まれてから今までに先天性異常、心臓、腎臓、肝臓、脳神経、免疫不全症、その他の病気にかかり医師の診察を受けていますか。病名	Yes はい	No いいえ	
If your child has been treated for any of the above, has the attending physician approved today's vaccination? その病気を診てもらっている医師に今日の予防接種を受けてよいといわれましたか	Yes はい	No いいえ	
Has your child ever experienced convulsions? ひきつけ(けいれん)をおこしたことがありますか when age: () 歳頃 If you answered "yes", did the child have a fever at that time? そのときに熱がでましたか	Yes はい Yes はい	No いいえ No いいえ	
Has your child ever developed a Rash, Hives or had any other reaction to medicine or food? 薬や食品で皮膚に発疹やじんましんが出たり、体の具合が悪くなったことがありますか	Yes はい	No いいえ	
Have any of your close relatives been diagnosed with a Congenital Immune Deficiency? 近親者の中に先天性免疫不全と診断されている方はいますか	Yes はい	No いいえ	
Has your child ever become ill from a vaccination? これまでに予防接種を受けて具合が悪くなったことがありますか If yes, what type of vaccination? () 予防接種の種類	Yes ある	No ない	
Has anyone of your close relatives ever become ill from a vaccination? 近親者に予防接種を受けて具合が悪くなった人はいますか	Yes はい	No いいえ	
Has your child had a blood transfusion or Gamma Globulin injection in the last six months? 6 か月以内に輸血あるいはガンマグロブリンの注射を受けましたか	Yes はい	No いいえ	
Do you have any questions regarding today's vaccination? 今日の予防接種について質問がありますか	Yes はい	No いいえ	
Physician's Comments 医師記入欄: Based on the above and the examination, today's vaccination is to be (conducted, withheld) 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 ・見合わせた方がよい) と判断します。 I have explained to the guardians on the effect and reactions of the vaccination as well as the Relief System for Injury to Health with the Vaccination. Physician's Signature or Name and Seal 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、説明しました。 医師署名または記名押印			

Having received a medical examination and explanation by a doctor, would you like to receive an inoculation with the understanding of the effect, the possibility of side reactions and the Relief System for Injury to Health with Vaccinations? (Yes / No) Please circle either yes or no in parenthesis.
医師の診察・説明を受け、予防接種の効果や目的、重篤な副反応の可能性、予防接種健康被害救済制度などについて理解した上で、接種することに (同意します・同意しません) カッコの中のどちらかを で囲んでください。
This questionnaire is intended to ensure the safety of vaccinations. I understand it and consent that this questionnaire will be sent to a municipal office. Parent's/Guardian's Signature
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Vaccine Name ワクチン名	Dosage (hypodermic injection) (皮下接種)	Medical Institution 実施医療機関 Physician 医師名
Lot No.	ml	Vaccination Date 接種年月日 平成 年 月 日

-globulin is a type of blood product injected to prevent infectious diseases such as type A hepatitis and to treat serious infectious diseases. For a three to six month interval following use, -globulin medication may weaken the effects of the measles vaccination.

Medical Questionnaire for Japanese Encephalitis Vaccination

日本脳炎予防接種予診票

(6-89 months after birth)

(生後 6 か月 ~ 90 か月 [7 歳 6 か月] 未満)

Cannot be used in medical institutions outside the city

Address 住所		ku (ward) 区	Body Temperature 診察前の体温	度 分		
Child's (Recipient's) Name 受ける人の氏名		見本	Telephone Number 電話	()		
Parent's/Guardian's Name 保護者の氏名			Male 男	Date of Birth 生年月日	Year 年	Month 月
		Female 女	Age: (満	Yrs. 歳	Months old か月)	

QUESTIONS	RESPONSES		PHYSICIAN'S COMMENTS
Have you read the explanation about today's vaccination (such as Vaccination Guide) distributed by local government? 今日受ける予防接種について市町村から配られている説明書(「予防接種のしおり」など)を読みましたか	Yes はい	No いいえ	
We will ask you about your child's growth. あなたのお子さんの発育歴についておたずねします What was your child's weight at birth? 出生体重 () grams Were there any unusual circumstances during delivery? 分娩時に異常がありましたか Were there any unusual circumstances after childbirth? 出生後に異常がありましたか Were you informed of any extraordinary conditions in your child at the child health examinations? 乳児健診で異常があるといわれたことがありますか	Yes あった Yes あった Yes ある	No なかった No なかった No ない	
Do you have any concerns about your child's health now? 今日体に具合の悪いところがありますか If you answered "yes", please write the specific symptoms: () 具体的な症状を書いてください	Yes はい	No いいえ	
Has your child been ill in the past one month? 最近 1 か月以内に病気にかかりましたか If you answered "yes", please write the name of illness and the date of recovery: () 病名・治ゆ日	Yes はい	No いいえ	
In the past one month, has your child been in contact with any person who has any of the following: Measles, Rubella, Chicken Pox and Mumps, etc? 1 か月以内に家族や遊び仲間などに麻疹、風しん、水痘、おたふくかぜなどの病気の方がいましたか If you answered "yes", please write the name of illness: () 病名	Yes はい	No いいえ	
Has your child had any vaccination in the past one month? 1 か月以内に予防接種を受けましたか If you answered "yes", please write the type of vaccination and the date: () 予防接種の種類、接種日	Yes はい	No いいえ	
Has your child ever been diagnosed for any of the following conditions; Congenital disorder, disease of Heart, Kidney, Liver, Brain Nerve, Immune Deficiency, and others? If you answered "yes", please write the name of illness: () 生まれてから今までに先天性異常、心臓、腎臓、肝臓、脳神経、免疫不全症、その他の病気にかかり医師の診察を受けていますか 病名	Yes はい	No いいえ	
If your child has been treated for any of the above, has the attending physician approved today's vaccination? その病気を診てもらっている医師に今日の予防接種を受けてよいといわれましたか	Yes はい	No いいえ	
Has your child ever experienced convulsions? ひきつけ(けいれん)をおこしたことがありますか when age: () 歳頃	Yes はい	No いいえ	
If you answered "yes", did the child have a fever at that time? そのときに熱がでましたか	Yes はい	No いいえ	
Has your child ever developed a Rash, Hives or had any other reaction to medicine or food? 薬や食品で皮膚に発疹やじんましんが出たり、体の具合が悪くなったことがありますか	Yes はい	No いいえ	
Have any of your close relatives been diagnosed with a Congenital Immune Deficiency? 近親者の中に先天性免疫不全と診断されている方はいますか	Yes はい	No いいえ	
Has your child ever become ill from a vaccination? これまでに予防接種を受けて具合が悪くなったことがありますか If yes, what type of vaccination? () 予防接種の種類	Yes ある	No ない	
Has anyone of your close relatives ever become ill from a vaccination? 近親者に予防接種を受けて具合が悪くなった人はいますか	Yes はい	No いいえ	
Has your child had a blood transfusion or Gamma Globulin injection in the last six months? 6 か月以内に輸血あるいはガンマグロブリンの注射を受けましたか	Yes はい	No いいえ	
Do you have any questions regarding today's vaccination? 今日の予防接種について質問がありますか	Yes はい	No いいえ	

Physician's Comments 医師記入欄:

Based on the above and the examination, today's vaccination is to be (conducted, withheld)

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 ・ 見合わせた方がよい) と判断します。

I have explained to the guardians on the effect and reactions of the vaccination as well as the Relief System for Injury to Health with the Vaccination.

Physician's Signature or Name and Seal

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、説明しました。

医師署名または記名押印

Having received a medical examination and explanation by a doctor, would you like to receive an inoculation with the understanding of the effect, the possibility of side reactions and the Relief System for Injury to Health with Vaccinations? (Yes / No) Please circle either yes or no in parenthesis.

医師の診察・説明を受け、予防接種の効果や目的、重篤な副反応の可能性、予防接種健康被害救済制度などについて理解した上で、接種することに (同意します・同意しません) カッコの中のどちらかを で囲んでください。

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Vaccine Name	Dosage	Medical Institution · Name of Physician · Date
Vaccine Name ワクチン名	(hypodermic injection) (皮下接種)	Medical Institution 実施医療機関 Physician 医師名 Vaccination Date 接種年月日
Lot No.	ml	平成 年 月 日

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Coupon for Stage I Initial vaccination-2
接種券 1 期初回-2

Medical Questionnaire for Japanese Encephalitis Vaccination

日本脳炎予防接種予診票

(6-89 months after birth)

(生後 6 か月 ~ 90 か月 [7 歳 6 か月] 未満)

Cannot be used in medical institutions outside the city

Address 住所		ku (ward) 区	Body Temperature 診察前の体温		度 分
Child's (Recipient's) Name 受ける人の氏名		見本	Telephone Number 電話		()
Parent's/Guardian's Name 保護者の氏名			Male 男 Female 女	Date of Birth 生年月日	Year Month Day 年 月 日 Age: Yrs. Months old (満 歳 か月)

QUESTIONS	RESPONSES		PHYSICIAN'S COMMENTS
Have you read the explanation about today's vaccination (such as Vaccination Guide) distributed by local government? 今日受ける予防接種について市町村から配られている説明書(「予防接種のしおり」など)を読みましたか	Yes はい	No いいえ	
We will ask you about your child's growth. あなたのお子さんの発育歴についておたずねします What was your child's weight at birth? 出生体重 () grams Were there any unusual circumstances during delivery? 分娩時に異常がありましたか Were there any unusual circumstances after childbirth? 出生後に異常がありましたか Were you informed of any extraordinary conditions in your child at the child health examinations? 乳児健診で異常があるといわれたことがありますか	Yes あった Yes あった Yes ある	No なかった No なかった No ない	
Do you have any concerns about your child's health now? 今日体に具合の悪いところがありますか If you answered "yes", please write the specific symptoms: () 具体的な症状を書いてください	Yes はい	No いいえ	
Has your child been ill in the past one month? 最近 1 か月以内に病気にかかりましたか If you answered "yes", please write the name of illness and the date of recovery: () 病名・治り日	Yes はい	No いいえ	
In the past one month, has your child been in contact with any person who has any of the following: Measles, Rubella, Chicken Pox and Mumps, etc? 1 か月以内に家族や遊び仲間に麻疹、風しん、水痘、おたふくかぜなどの病気の方がいましたか If you answered "yes", please write the name of illness: () 病名	Yes はい	No いいえ	
Has your child had any vaccination in the past one month? 1 か月以内に予防接種を受けましたか If you answered "yes", please write the type of vaccination and the date: () 予防接種の種類、接種日	Yes はい	No いいえ	
Has your child ever been diagnosed for any of the following conditions; Congenital disorder, disease of Heart, Kidney, Liver, Brain Nerve, Immune Deficiency, and others? If you answered "yes", please write the name of illness: () 生まれてから今までに先天性異常、心臓、腎臓、肝臓、脳神経、免疫不全症、その他の病気にかかり医師の診察を受けていますか 病名	Yes はい	No いいえ	
If your child has been treated for any of the above, has the attending physician approved today's vaccination? その病気を診てもらっている医師に今日の予防接種を受けてよいといわれましたか	Yes はい	No いいえ	
Has your child ever experienced convulsions? ひきつけ(けいれん)をおこしたことがありますか when age: () 歳頃	Yes はい	No いいえ	
If you answered "yes", did the child have a fever at that time? そのときに熱がでましたか	Yes はい	No いいえ	
Has your child ever developed a Rash, Hives or had any other reaction to medicine or food? 薬や食品で皮膚に発疹やじんましんが出たり、体の具合が悪くなったことがありますか	Yes はい	No いいえ	
Have any of your close relatives been diagnosed with a Congenital Immune Deficiency? 近親者の中に先天性免疫不全と診断されている方はいますか	Yes はい	No いいえ	
Has your child ever become ill from a vaccination? これまでに予防接種を受けて具合が悪くなったことがありますか If yes, what type of vaccination? () 予防接種の種類	Yes ある	No ない	
Has anyone of your close relatives ever become ill from a vaccination? 近親者に予防接種を受けて具合が悪くなった人はいますか	Yes はい	No いいえ	
Has your child had a blood transfusion or Gamma Globulin injection in the last six months? 6 か月以内に輸血あるいはガンマグロブリンの注射を受けましたか	Yes はい	No いいえ	
Do you have any questions regarding today's vaccination? 今日の予防接種について質問がありますか	Yes はい	No いいえ	
Physician's Comments 医師記入欄: Based on the above and the examination, today's vaccination is to be (conducted, withheld) 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 ・ 見合わせた方がよい) と判断します。I have explained to the guardians on the effect and reactions of the vaccination as well as the Relief System for Injury to Health with the Vaccination. Physician's Signature or Name and Seal 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、説明しました。 医師署名または記名押印			

Having received a medical examination and explanation by a doctor, would you like to receive an inoculation with the understanding of the effect, the possibility of side reactions and the Relief System for Injury to Health with Vaccinations? (Yes / No) Please circle either yes or no in parenthesis.
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Vaccine Name ワクチン名	Dosage (hypodermic injection) (皮下接種)	Medical Institution 実施医療機関 Physician 医師名 Vaccination Date 接種年月日
Lot No.	ml	Year Month Day 平成 年 月 日

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Vaccinations Available at Public Health and Welfare Centers

福祉保健センターで受ける予防接種

Vaccine implementation depends on each local administration.

Type	Recommended age (standard vaccination age)	Number of Times	Implementation term	Valid period (for free vaccinations)
Polio	3 – 18 months after birth	2	Generally Apr. & Oct.	3– 89 months after birth

- ◆ The vaccination schedules are informed in the bulletin of Yokohama (ward version) (Koho Yokohama) and elsewhere.
- ◆ Be sure that your child is in good health when he/she takes vaccinations.
- ◆ On the day of a vaccination, take your child's body temperature before leaving home to confirm that it is normal.
- ◆ When taking a vaccination, read the Vaccination Handbook(Yobosesyu-no Shiori) carefully and fill in the required information in Vaccination Questionnaire in this book at home, and bring them with you to the Public Health and Welfare Center.
- ◆ The leaflet "Vaccination Handbook" (Yobosesshu-no Shiori) is distributed at Public Health and Welfare Centers.
- ◆ Be sure to bring your Mother and Child Health Handbook (Boshi Kenko Techo) so that the vaccination can be recorded on it.
- ◆ Read "Cautions following Vaccinations" (Sesshugo no Chui) carefully after the vaccination is taken.
- ◆ Please inquire at the Public Health and Welfare Center if you have any concerns or difficulties.
- ◆ Polio vaccinations can be taken up to 89 months (age 7 years and 5 months) after birth ; however, it is recommended that you have your child take these vaccinations at the recommended ages shown in the table above.

Medical Questionnaire for Polio Vaccination

(Please indicate if this is your 1st visit or 2nd visit, circle either: 1st 2nd)

ポリオ予防接種予診票 (1回目・2回目)
(3-89 months after birth)

City of Yokohama

(生後3か月~90か月[7歳6か月]未満)

Can be used at Public Health and Welfare center only

Child's (Recipient's) Name 受ける人の氏名		In Hiragana 仮りがな		Body Temperature at the venue 診察前(会場)の体温		度 分	
Parent's/Guardian's Name 保護者の氏名				Male 男	Date of Birth 生年月日	Year 年	Month 月
Address 住所		ku (ward) 区		Female 女		Day 日	Age: (満
				Telephone Number 電話		Yrs. 歳	Months old か月)



QUESTIONS	RESPONSES		PHYSICIAN'S COMMENTS
Have you read the explanation about today's vaccination (Vaccination Guide) distributed by the City of Yokohama? 今日受ける予防接種について横浜市から配られている説明書(予防接種のしおり)を読みましたか	Yes はい	No いいえ	
Has your child had any vaccination in the past one month? 1か月以内に予防接種を受けましたか	Yes はい	No いいえ	
If you answered "yes", please write the type of vaccination and the date: () 予防接種の種類、接種日			
We will ask you about your child's growth. あなたのお子さんの発育歴についておたずねします			
What was your child's weight at birth? 出生体重 () grams Were there any unusual circumstances during delivery? 分娩時に異常がありましたか Were there any unusual circumstances after childbirth? 出生後に異常がありましたか Were you informed of any extraordinary conditions in your child at the child health examinations? 乳児健診で異常があるといわれたことがありますか	Yes あった Yes あった Yes ある	No なかった No なかった No ない	
Do you have any concerns about your child's health now? 今日体に具合の悪いところがありますか	Yes はい	No いいえ	
If you answered "yes", please write the specific symptoms () 具体的な症状を書いてください			
In the past one month, has your child been in contact with any person who has any of the following: Measles, Rubella, Chicken Pox and Mumps, etc.? 1か月以内に家族や遊び仲間に麻疹、風しん、水痘、おたふくかぜなどの病気の方がいましたか	Yes はい	No いいえ	
If you answered "yes", please write the name of illness: () 病名			
Has your child been ill in the past one month? 最近1か月以内に病気にかかりましたか	Yes はい	No いいえ	
If you answered "yes", please write the name of illness and the date of recovery: () 病名 治ゆ日			
Has your child ever been diagnosed for any of the following conditions; Congenital disorder, disease of Heart, Kidney, Liver, Brain Nerve, Immune Deficiency, and others? If you answered "yes", please write the name of illness: () 生まれてから今までに先天性異常、心臓、腎臓、肝臓、脳神経、免疫不全症、その他の病気にかかり医師の診察を受けていますか 病名	Yes はい	No いいえ	
If your child has been treated for any of the above, has the attending physician approved today's vaccination? その病気を診てもらっている医師に今日の予防接種を受けてよいといわれましたか	Yes はい	No いいえ	
Has your child ever experienced convulsions? ひきつけ(けいれん)をおこしたことがありますか 歳頃	Yes はい	No いいえ	
If you answered "yes", did the child have a fever at that time? そのときに熱がでましたか	Yes はい	No いいえ	
Has your child ever developed a Rash, Hives or had any other reaction to medicine or food? 薬や食品で皮膚に発疹やじんましんが出たり、体の具合が悪くなったことがありますか	Yes はい	No いいえ	
Have any of your close relatives been diagnosed with a Congenital Immune Deficiency? 近親者に先天性免疫不全と診断されている方はいますか	Yes はい	No いいえ	
Has your child ever become ill from a vaccination? これまでに予防接種を受けて具合が悪くなったことがありますか	Yes はい	No いいえ	
If yes, what type of vaccination? () 予防接種の種類			
Has anyone of your close relatives ever become ill from a vaccination? 近親者に予防接種を受けて具合が悪くなった人はいますか	Yes はい	No いいえ	
Has your child had a blood transfusion or Gamma Globulin injection in the last six months? 6か月以内に輸血あるいはガンマグロブリンの注射を受けましたか	Yes はい	No いいえ	
Do you have any questions regarding today's vaccination? 今日の予防接種について質問がありますか	Yes はい	No いいえ	

Physician's Comments 医師記入欄:
Based on the above and the examination, today's vaccination is to be (conducted, withheld)
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・見合わせた方がよい) と判断します。I have explained to the guardians on the effect and reactions of the vaccination as well as the Relief System for Injury to Health with the Vaccination. Physician's Signature or Name and Seal
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、説明しました。 医師署名または記名押印

Having received a medical examination and explanation by a doctor, would you like to receive an inoculation with the understanding of the effect, the possibility of side reactions and the Relief System for Injury to Health with Vaccinations? (Yes / No) Please circle either yes or no in parenthesis.
医師の診察・説明を受け、予防接種の効果や目的、重篤な副反応の可能性、予防接種健康被害救済制度などについて理解した上で、接種することに (同意します・同意しません) カッコの中のどちらかを で囲んでください。
This questionnaire is intended to ensure the safety of vaccinations. I understand it and consent that this questionnaire will be sent to a municipal office. Parent's/Guardian's Signature
この予診票は、予防接種の安全性の確保を目的としています。このことを理解の上、本予診票が市町村に提出されることに同意します。保護者自署

Vaccine Name ワクチン名	Dosage Oral application of the certain amount of 0.05 ml (規定量 0.05ml を経口投与)	Medical Institution 実施医療機関 Physician 医師名 Vaccination Date 接種年月日	Name of Physician 氏名	Date 平成 年 月 日
Lot No.				

-globulin is a type of blood product injected to prevent infectious diseases such as type A hepatitis and to treat serious infectious diseases. For a three to six month interval following use, -globulin medication may weaken the effects of the measles vaccination.

Medical Questionnaire for Polio Vaccination

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(Please indicate if this is your 1st visit or 2nd visit, circle either: 1st 2nd)

ポリオ予防接種予診票 (1回目・2回目)
(3-89 months after birth)

City of Yokohama

(生後3か月～90か月[7歳6か月]未満)

Can be used at Public Health and Welfare center only

Child's (Recipient's) Name 受ける人の氏名		In Hiragana 仮りがな		Body Temperature at the venue 診察前(会場)の体温		度 分		
Parent's/Guardian's Name 保護者の氏名		見本		Male 男	Date of Birth 生年月日	Year 年	Month 月	Day 日
Address 住所				Female 女	Age: (満)	Yrs. 歳	Months old か月)	
		ku (ward) 区		Telephone Number 電話				

QUESTIONS	RESPONSES		PHYSICIAN'S COMMENTS
Have you read the explanation about today's vaccination (Vaccination Guide)distributed by the City of Yokohamat? 今日受ける予防接種について横浜市から配られている説明書(予防接種のしおり)を読みましたか	Yes はい	No いいえ	
Has your child had any vaccination in the past one month? 1か月以内に予防接種を受けましたか If you answered "yes", please write the type of vaccination and the date: () 予防接種の種類、接種日	Yes はい	No いいえ	
We will ask you about your child's growth. あなたのお子さんの発育歴についておたずねします What was your child's weight at birth? 出生体重 () grams Were there any unusual circumstances during delivery? 分娩時に異常がありましたか Were there any unusual circumstances after childbirth? 出生後に異常がありましたか Were you informed of any extraordinary conditions in your child at the child health examinations? 乳児健診で異常があるといわれたことがありますか	Yes あった Yes あった Yes ある	No なかった No なかった No ない	
Do you have any concerns about your child's health now? 今日体に具合の悪いところがありますか If you answered "yes", please write the specific symptoms () 具体的な症状を書いてください	Yes はい	No いいえ	
In the past one month, has your child been in contact with any person who has any of the following: Measles, Rubella, Chicken Pox and Mumps, etc.,? 1か月以内に家族や遊び仲間に麻疹、風しん、水痘、おたふくかぜなどの病気の方がいましたか If you answered "yes", please write the name of illness: () 病名	Yes はい	No いいえ	
Has your child been ill in the past one month? 最近1か月以内に病気にかかりましたか If you answered "yes", please write the name of illness and the date of recovery: () 病名 治ゆ日	Yes はい	No いいえ	
Has your child ever been diagnosed for any of the following conditions; Congenital disorder, disease of Heart, Kidney, Liver, Brain Nerve, Immune Deficiency, and others? If you answered "yes", please write the name of illness: () 生まれてから今までに先天性異常、心臓、腎臓、肝臓、脳神経、免疫不全症、その他の病気にかかり医師の診察を受けていますか 病名	Yes はい	No いいえ	
If your child has been treated for any of the above, has the attending physician approved today's vaccination? その病気を診てもらっている医師に今日の予防接種を受けてよいといわれましたか	Yes はい	No いいえ	
Has your child ever experienced convulsions? ひきつけ(けいれん)をおこしたことがありますか 歳頃 If you answered "yes", did the child have a fever at that time? そのときに熱がでましたか	Yes はい	No いいえ	
Has your child ever developed a Rash, Hives or had any other reaction to medicine or food? 薬や食品で皮膚に発疹やじんましんが出たり、体の具合が悪くなったことがありますか	Yes はい	No いいえ	
Have any of your close relatives been diagnosed with a Congenital Immune Deficiency? 近親者に先天性免疫不全と診断されている方はいますか	Yes はい	No いいえ	
Has your child ever become ill from a vaccination? これまでに予防接種を受けて具合が悪くなったことがありますか If yes, what type of vaccination? () 予防接種の種類	Yes ある	No ない	
Has anyone of your close relatives ever become ill from a vaccination? 近親者に予防接種を受けて具合が悪くなった人はいますか	Yes はい	No いいえ	
Has your child had a blood transfusion or Gamma Globulin injection in the last six months? 6か月以内に輸血あるいはガンマグロブリンの注射を受けましたか	Yes はい	No いいえ	
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Vaccine Name ワクチン名	Dosage Oral application of the certain amount of 0.05 ml (規定量 0.05ml を経口投与)	Medical Institution 実施医療機関 Physician 医師名 Vaccination Date 接種年月日	Year 年	Month 月	Day 日
Lot No.		平成			

-globulin is a type of blood product injected to prevent infectious diseases such as type A hepatitis and to treat serious infectious diseases. For a three to six month interval following use, -globulin medication may weaken the effects of the measles vaccination.