

# BCG vaccine medical questionnaire (yoshin-hyo)(BCG 専用予診票)

※医療機関の皆様へ：この予診票はみほんです。医師会への請求等は、日本語版の予診票を使用して下さい。  
 ※この予診票だけでは接種できません。こちらを参照に、正規の予診票(2枚複写)に転記して使用して下さい。  
 ※This english version yoshin-hyo cannot be use separately. Please transfers them to the Japanese version yoshin-hyo(2sheets).

(Eligible vaccination age : Before reaching age 1)

Cannot be used at medical institutions outside of Yokohama      Yokohama City      Body temperature taken before examination: \_\_\_\_\_°C

Address	Ward		Telephone No.	
Name of Person to Receive Vaccination		Male / Female	Date of birth (YY/MM/DD)	/ / Age: ___ years months
Name of Parent/Guardian				

Questionnaire	Response Column		Filled in by Physician
Have you read the Guide to Vaccinations for Children and other informational materials distributed by Yokohama City?	Yes	No	
Please tell us about your child's developmental history: Birth weight: _____g			
Was any abnormality detected at the time of delivery?	Yes	No	
Was any abnormality detected following delivery?	Yes	No	
Was any abnormality detected during any of your child's health checks as an infant or young child?	Yes	No	
Is your child feeling physically unwell in any way today? If so, please describe symptoms in detail: ( )	Yes	No	
Has your child been ill within the last month? Name of illness(es) and date(s) of recovery: ( )	Yes	No	
Have any of the child's family members or other person around your child ever suffered (from birth until now) from tuberculosis?	Yes	No	
Has your child received any vaccination within the last month? Type of vaccination and vaccination date: ( )	Yes	No	
Has your child ever been diagnosed (from birth until now) with a congenital abnormality, a heart, kidney, liver and/or cranial nerve problem; immunodeficiency; or any other such condition? Disease/condition name(s): ( )	Yes	No	
If applicable, did the doctor who examined your child for the above condition(s) approve of today's vaccination?	Yes	No	
Has your child ever suffered a seizure (convulsions)? Approximate age: ( )	Yes	No	
If so, did your child have a fever at the time?	Yes	No	
Has any of your child's close relatives ever been diagnosed with congenital immunodeficiency?	Yes	No	
Has your child ever felt unwell following vaccination? Type of vaccine: ( )	Yes	No	
Has any of the child's close relatives ever felt unwell following vaccination?	Yes	No	
Do you have any questions about today's vaccination?	Yes	No	

To be filled out by the physician:  
 In light of the above questionnaire responses and health examination,  
 I have decided that today's vaccination will be (administered / postponed).  
 I have explained the effects and side effects of the vaccination, relief measures available in the case of adverse effects on the recipient's health, and other relevant information to the parent/guardian.  
 Physician signature or name and seal      ※日本語版に署名して下さい

Following a health examination and relevant explanations, I (consent to / do not consent to) my child's vaccination based on an understanding of the effects and purpose of vaccination, the possibility of severe side effects, relief measures in response to adverse health effects from vaccination, etc.  
 \* Please circle either "consent to" or "do not consent to" in the parentheses above.  
 The purpose of this questionnaire is to ensure safety during vaccination. Based on an understanding of the above, I consent to the submission of this questionnaire form to Yokohama City.  
 Parent/guardian signature: \_\_\_\_\_      ※日本語版に署名して下さい

Lot no of Vaccine	Inoculum Dose	Administering Medical Institution, Physician's Name and Vaccination Date
Lot no.	Subcutaneous inoculation with the predetermined amount of vaccine using a tube-like apparatus containing multiple needles	Administering Medical Institution: Administering Physician's Name: Vaccination Date (YY/MM/DD): / /      ※日本語版に記入して下さい

## ◆◆ Precautions Following BCG Vaccine Inoculation ◆◆

### ■ Precautions Following Inoculation

1. Have the child monitored at the medical institution or ensure that a doctor can be contacted immediately for 30 minutes following the inoculation. Sudden side effects in reaction to the vaccination sometimes occur during this period.
2. Keep an eye out for the occurrence of side effects for four hours following inoculation.
3. Keep the injection sites clean. Although bathing is permitted following vaccination, **make sure to avoid scrubbing or rubbing the injection sites.**
4. If any unusual reaction occurs near the injection sites or the child's physical condition changes in any way, have the child examined by a doctor immediately.

### ■ Regular Reactions and Koch's Phenomenon

#### 1. Regular Reactions

Red spots will appear **about 10 days after inoculation**, and they may contain small amounts of pus. This reaction is strongest about 4 weeks after injection but will heal naturally within 3 months' time. Avoid applying bandages and keep the area clean.

#### 2. Koch's Phenomenon

If the child has already been infected with tuberculosis, reddening, swelling, pus from holes created by the injection needles and other such symptoms may occur **within 10 days of inoculation**. This is known as Koch's phenomenon. If the injection sites are kept clean, these symptoms normally dissipate within 2–4 weeks.

However, **if you observe a reaction that resembles Koch's phenomenon, your child must be examined to determine whether s/he has been infected with tuberculosis. Please contact the medical institution that administered the vaccine or your local ward office's Health and Welfare Center.**

### ■ Side Effects of the BCH Vaccine

In rare cases, swelling of the lymph nodes in the armpit on the same arm as the injection sites may occur roughly one month after inoculation. If you keep an eye on their condition, they will return to normal. Visit a doctor if the area near the injection sites becomes inflamed, swells excessively, or accumulates and releases pus (after natural breakage).

### ■ Interval Until Next Inoculation

The next dose can be administered 27 days or more after the current BCG inoculation.