For submission to the Health and Welfare Bureau (1st sheet)

City of Yokohama

Preliminary Medical Checkup Sheet for Rotavirus Vaccination

Please tell us about your child's rotavirus vaccination history.
This will be my child's _____ time to receive the rotavirus vaccination.
(Please circle the type of vaccine and the number of times your child will have received it as of today.)

Rotarix (RV1) (2 doses) From the age of 6 weeks 0 days up until 24 weeks 0 days	1st	2nd	
RotaTeq (RV5) (3 doses) From the age of 6 weeks 0 days up until 32 weeks 0 days	1st	2nd	3rd

For use only at cooperating medical institutions in Yokohama City.
Please fill in all the information in the bold boxes.
Please bring your Mother and Child Health Handbook with you on the day of vaccination.

Address	Yokohama		Tel.
Address	Katakana	Sex M / F	Date of birth (YYYY) (MM) (DD) (weeks days since birth) Calculate using the day after the child was born as one day
Name of guardian			Body temperature on the day ºC

Questions	Answer column		Physician's use only
If this is the first dose of the rotavirus vaccine, as of today, has 14 weeks and 6 days elapsed since the birth of your child?	Yes	No	
If this is the second or third dose of the rotavirus vaccine, is your child having the same type of vaccine as on the previous occasion? Vaccine name ( ) Has there been an interval of at least 27 days since the last dose? Date of last vaccination ( )	Yes Yes	No No	
Have you read the information sheet (Vaccination Guide, etc.) distributed by the City of Yokohama regarding today's vaccination?	Yes	No	
Do you understand the effects and potential side effects, etc. of today's vaccination?	Yes	No	
Did you receive and understand the explanation about intestinal intussusception?	Yes	No	
Please tell us about your child's developmental history. Birth weight ( ) g Where there any abnormalities during delivery? Were there any abnormalities after birth? Has your child been diagnosed with any abnormality at the infant health examination?	Yes Yes Yes	No No No	
Does your child feel unwell in any way today? If so, please describe his or her symptoms ( )	Yes	No	
Has your child been sick at any time in the past month? Name of illness ( )	Yes	No	
Has anyone in your family or your child's playmates had measles, rubella, chicken pox, or mumps within the past month? Name of illness ( )	Yes	No	
Has your child received any vaccinations within the past month? Type of vaccination, date of vaccination ( )	Yes	No	
Has your child ever had intestinal intussusception? Does your child have a congenital gastrointestinal disorder for which he or she has not completed treatment? *If this is the case, your child cannot receive the rotavirus vaccine.	Yes	No	
Has your child ever been diagnosed with immunodeficiency? Has he or she ever had infections such as pneumonia or otitis media, had repeated diarrhea, or experienced poor weight gain? *If this is the case, your child may not be able to receive the rotavirus vaccine.	Yes	No	
Has your child received a medical diagnosis for any congenital anomaly, gastrointestinal disorders, heart, kidney, liver, blood, cranial nerve, or other condition since birth? Name of condition ( )	Yes	No	
Has the doctor who is treating your child for this condition told you that he or she can receive the vaccination today?	Yes	No	
Has your child ever had a seizure (convulsion)? At what age? _____ months	Yes	No	
Did he or she have a fever on this occasion?	Yes	No	
Has your child ever had a skin rash, hives, or other health problems caused by medicines or foods? Name of medicine/food ( )	Yes	No	
Has your child ever fallen sick after receiving a vaccination? Type of vaccination ( )	Yes	No	
Did the mother of this child receive any immunosuppressive medication during pregnancy? Name of medication ( )	Yes	No	
Has anyone in your immediate family ever been diagnosed with congenital immunodeficiency?	Yes	No	
Has anyone in your immediate family ever fallen sick after receiving a vaccination?	Yes	No	
Has your child ever had a blood transfusion or gamma globulin injection?	Yes	No	
Do you have any questions about today's vaccination?	Yes	No	

Physician's use only	Medical examination findings	Body temperature before examination ºC	Physician has verified vaccine expiration date ☐	[Physician's signature or name and seal]
	Based on the above interview and examination, I judge that the vaccination today can be administered / should be postponed. I explained the expected effects of the vaccination, potential side effects (especially the possibility of intestinal intussusception), and the Relief System for Sufferers from Adverse Drug Reactions to the guardian of the patient.			

For the attention of the guardian	Having received a medical examination and explanation from a physician, and having understood the effects and purpose of the vaccination, the possibility of serious side effects (especially the possibility of intestinal intussusception), and the Relief System for Sufferers from Adverse Drug Reactions I hereby (agree / disagree) to have my child vaccinated. *Circle to indicate whether you agree or disagree. The purpose of this medical checkup sheet is to ensure the safety of vaccinations. I understand the purpose of this medical checkup sheet and agree to have it submitted to the City of Yokohama.	[Guardian's signature]

Name of vaccine used	Dose administered		Administering medical institution, name of physician, date of vaccination
Name of vaccine	Oral vaccination		Administering medical institution:
	Rotarix®	RotaTeq®	Name of physician:
Lot No.	1.5mL	2.0mL	Date of vaccination: (YYYY) (MM) (DD)