Pre-vaccination Check Sheet（ **years** **months**）

Date：Y / M / D

◆ Please check one of the following vaccinations which you want your child to be vaccinated today.

（ ）Hib --- 1st 2nd 3rd booster
（ ）PCV --- 1st 2nd 3rd booster （ ）Rota --- 1st 2nd
（ ）BCG（ ）Tuberculin reaction test
（ ）DPT-IPV --- 1st 2nd 3rd booster （ ）DT
（ ）MR （ ）Measles （ ）Rubella
（ ）Japanese encephalitis --- 1st 2nd 3rd
（ ）Mumps （ ）Chickenpox （ ）Influenza --- 1st 2nd
（ ）_____

（ ）Hepatitis B --- 1st 2nd 3rd
（ ）Prevention of vertical transmission for HB

◆ **Today's body temperature (℃) taken time (:)**

Questions	Answers
Birth weight: ( ) g	
Was there any trouble at the birth?	Yes / No
Was there any trouble after birth?	Yes / No
Has any disorder been pointed out by a doctor at check-ups?	Yes / No
Is your child sick today? ---If answer is yes, write the symptoms. ( )	Yes / No
Has your child been sick within the last month? ---If answer is yes, write the name of the illness. ( )	Yes / No
Have any of your family members or the child's friends had Measles, Rubella, Chickenpox or Mumps within the last month? ---If answer is yes, write the name of the disease. ( )	Yes / No
Has your child received any kind of vaccine within the last month? ---If answer is yes, write the name of the vaccine. ( )	Yes / No
Has your child had any of the following special disease, such as Congenital disorder, Heart disease, Liver disease, Neurological disorder, or Immuno-deficiency? ---If answer is yes, write the name of the disorder. ( ) Has the physician in charge permitted your child to receive today's vaccination?	Yes / No Yes / No
Has your child ever had any convulsions? ---If answer is yes, when has your child had it? :At ( )years old, (with / without) fever.	Yes / No
Has your child ever developed skin rash or discomfort with food or drugs?	Yes / No
Have any of your children been diagnosed with a congenital Immuno-deficiency?	Yes / No
Has your child ever got sick after a vaccination? ---If answer is yes, write the name of the vaccination. ( )	Yes / No
Have any members of your family got sick after a vaccination?	Yes / No
Has your child received a blood transfusion or γ-globulin therapy within the last 6 month?	Yes / No
Do you have any questions about today's vaccination?	Yes / No
Having received the explanation of the health check result, do you want your child to be vaccinated today?	Yes / No

Parent's signature: _____

☆Only for Influenza vaccination: Does your child have allergy to eggs?	Yes / No

◆ **Doctor's decision:** With the result of today's health check, today's vaccination **(can be done / should be postponed)**

Doctor's signature: _____