Ritsumeikan Health Center/Clinic　Preliminary Examination for Vaccination

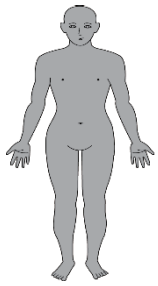
Date of vaccination:　　Body temperature　　°C

Address	Cell phone number　(　) Phone number　(　)
Name	Person receiving the vaccination ***Vaccinations cannot be given without the signature of a guardian/parent (requirement for minors)**
Date of birth	YYYY / MM / DD　　years old

Vaccines

1. Hepatitis A vaccine ····· (1st/2nd) (Additional:　　time(s))
2. Hepatitis B vaccine ····· (1st/2nd) (Additional:　　time(s))
3. Measles vaccine ····· (1st/2nd) (Additional:　　time(s))
4. Rubella vaccine ····· (1st/2nd) (Additional:　　time(s))
5. Measles/Rubella vaccine (MR)····· (1st/2nd) (Additional:　　time(s))
6. Chickenpox vaccine····· (1st/2nd) (Additional:　　time(s))
7. Mumps vaccine····· (1st/2nd) (Additional:　　time(s))
8. Tetanus toxoid ····· (1st/2nd) (Additional:　　time(s))
9. Diphtheria/Tetanus vaccine (DT) ····· (1st/2nd) (Additional:　　time(s))
10. Diphtheria/Pertussis/Tetanus vaccine (DPT)(1st/2nd/3rd) (Additional:　　time(s))
11. Japanese encephalitis vaccine····· (1st/2nd) (Additional:　　time(s))
12. Inactivated polio vaccine····· (1st/2nd/3rd) (Additional:　　time(s))
13. Meningococcal vaccine ····· (1st) (Additional:　　time(s))
14. Influenza vaccine ····· (1st) (Additional:　　time(s))
15. Rabies vaccine (made in Japan) ····· (1st/2nd/3rd) (Additional:　　time(s))
16. Tdap vaccine **(imported)**····· (1st) (Additional:　　time(s))
17. Typhoid vaccine **(imported)** ····· (1st) (Additional:　　time(s))
18. Rabies vaccine **(imported)** ····· (1st/2nd/3rd) (Additional:　　time(s))

Attach a lot sticker to the vaccine received



Questions	Answers		Entered by the physician
Have you read the explanation (separate sheet) on the vaccine you will receive today and understood its efficacy and side effects?	Yes	No	
Are you feeling sick today? Describe specifically (　　)	Yes	No	
Have you had a fever or illness within the last month? (　　)	Yes	No	
Are you receiving treatment for any disease (e.g., hypertension, diabetes mellitus)? Disease name, drug name (　　)	Yes	No	
Did the primary physician for that disease agree that you can have today's vaccine?	Yes	No	
Have any of your family members or friends had measles, rubella, chickenpox, or mumps within the last month? Who had which disease? (　　)	Yes	No	
Have you received any vaccinations within the last 4 weeks? Vaccination name (　　)	Yes	No	
Have you ever felt sick after having a vaccination? Vaccination name (　　)	Yes	No	
Have you ever had any diseases e.g., congenital abnormality, heart/kidney/liver/cranial nerve disease, immunodeficiency disease, blood disease? Disease name (　　)	Yes	No	
Have you ever developed a rash or hives, or felt sick after taking drugs or foods (particularly those derived from chicken eggs, poultry, and other chicken-derived products)? Drug name/product name (　　)	Yes	No	
Have you ever been diagnosed with any respiratory diseases such as interstitial pneumonia or bronchial asthma?	Yes	No	
Have you ever had a convulsions (spasm)?	Yes	No	
Have you received a blood transfusion or gamma globulin injections within the last 6 months?	Yes	No	
Do you have any close relatives with a congenital immunodeficiency?	Yes	No	
Do you have any close relatives who felt sick after a vaccination?	Yes	No	
[For females] Are you currently pregnant or possibly pregnant? Note: It is important to avoid becoming pregnant for 2 months after receiving a live vaccine.	Yes	No	

Entered by the physician	Based on the results of a medical interview and consultation, an explanation was provided on the efficacy, side effects, and relief for any health damage. **Vaccination [Possible/Not possible]**	Physician's signature

Signature of the person receiving the vaccination or a parent/guardian	I was examined by the physician and understood the efficacy and purpose of the vaccination, possibility of side effects, and the relief system for any health reactions. I agree to have the vaccination and wish to have it today.	Signature of the person receiving the vaccination or a parent/guardian (own signature)

November 2019