

## Questionnaire for DT(Diphtheria, Tetanus,) vaccine Chiba City

住所 Address	千葉市 区				電話 Tel.	- -			
予防接種番号 Vaccination No.					実施日 ※医療機関記載欄 Date to be administered ※ to be filled in by medical institution				
フリガナ Name in Katakana				性別 sex	西暦 2 0	年 year	月 month	日 date	
氏名 Name	保護者氏名 (Parent/Guardian Name)								
生年月日 Date of Birth	西暦 Year	年	月	日	子の満年齢 Age of the child	歳 years	か月 ※9歳以上が対象 Months ※Children of older than 9 years old		
(↑予防接種番号シールをはってください) (↑ Place the vaccination number sticker here)				診察前の体温 Body temperature before exam.		度 °C	分 Degree C		

保護者の方は太線枠内を記入してください。

Parent/guardian, ; Please fill those cells surrounded by thick line.

質問事項 Questionnaire for Vaccination	回答欄 Answers		医師記入欄 Doctor's comment
今日受ける予防接種について、千葉市から配られている説明書を読みましたか。 Have you read the document from Chiba City explaining about today's vaccination?	いいえ No	はい Yes	
あなたのお子さんの発育歴についてお尋ねします。 Please answer following questions about the growth history of the child.	あった Yes	なかった No	
出生体重 ( ) g 分娩時に異常がありましたか Birth weight ( ) g Did the child have any abnormalities at delivery?	Yes	No	
出生後に異常がありましたか。 Did the child have any abnormalities after birth?	あった Yes	なかった No	
乳幼児健診で異常があるとされたことがありますか。 Were any abnormalities found in infant health checks?	ある Yes	ない No	
今日体に具合の悪いところがありますか。 Does the child have any poor conditions today? 具体的な症状を書いてください。( ) If so, describe symptoms. ( )	はい Yes	いいえ No	
最近1か月以内に病気にかかりましたか。 Did the child become ill in the past month? 病名 ( 月 日 : ) Name the disease and date. (Date : )	はい Yes	いいえ No	
1か月以内に、家族や遊び仲間にはしか、風しん、みずぼうそう、おたふくかぜなどの病気の方がいましたか。 Have any family members or friends of the child had measles, rubella, chicken pox or mumps in the past month? Describe name of disease and date (Date : )	はい Yes	いいえ No	
1か月以内に予防接種を受けましたか。(日付：種類) Did the child have any vaccinations in the past month? dates and names ( )	はい Yes	いいえ No	
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(投薬など)を受けていますか。 Did the child have any congenital abnormalities, heart, kidney, liver, cranial nerve, immune deficiency, or any other diseases since birth, on which you have consulted with any doctors including dosage? 病名 ( ) Disease names ( )	はい Yes	いいえ No	
その病気の主治医には、今日の予防接種を受けてよいと言われましたか。 Did the doctors in charge of the above diseases agree to the child receiving today's vaccination?	いいえ No	はい Yes	
ひきつけ(けいれん)をおこしたことがありますか。( 歳 か月頃 ) Had the child a convulsion or fit in the past? If so, around what age? ( years months)	はい Yes	いいえ No	
そのとき熱がでましたか。 If you answered " yes" to the above, did the child have a temperature at the same time?	はい Yes	いいえ No	

※この用紙は機械で読み取りますので黒ボールペンで丁寧に書いてください。

As this sheet is read by a machine, please write carefully with a black ball point pen.

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。 Has the child ever had a rash or hives on his skin, or become ill with medications or food?	はい Yes	いいえ No	
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。予防接種名 ( ) Has the child had a serious reaction to a vaccine in the past? Name of Vaccine ( )	ある Yes	ない No	
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 Have any close relatives of the child had a serious reaction to a vaccine?	はい Yes	いいえ No	
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。 Have any close relatives of the child been diagnosed as congenital immune deficiency?	はい Yes	いいえ No	
6か月以内に輸血或いはガンマグロブリンの注射を受けましたか。 Has the child received a transfusion of blood or an Injection of gamma globulin in the past 6 months?	はい Yes	いいえ No	
今日の予防接種について質問がありますか。 ある場合 ( ) Do you have any questions about today's vaccination? If yes, please describe. ( )	はい Yes	いいえ No	

メーカー名 Manufacturer			実施医療機関名 Name of Institution		Code	
Lot No.						
有効期限 Expiration date	西暦 A.D.	年 Year	月 Month	日 date		
接種の適否 Propriety of inoculation	接種量 Dosage		接種医師名(接種否の場合は判定医師) Doctor's Name. In case of NO, name of the Doctor who made the judgment.			Code
1. 適 YES 2. 否 NO	3	0.1ml	皮下接種 Hypodermic injection			

医師の記入欄  
保護者に対して、予防接種の効果、副反応および予防接種健康被害救済制度について、説明をしました。  
Doctor's column

医師署名又は記名押印

I made explanation on the effectiveness of the vaccination, side reactions, and the inoculation health hazard relief system.

**Signature or seal of the Doctor in charge**

**This column is to be filled in by parent/guardian or by the representative.** (In case of a representative, a power of attorney is required separately.)

The child has received medical examination and I received the explanation by the doctor. I further received explanation about the effects, purpose, potential serious side effects of the vaccination and inoculation health relief system. Based on the above, I (**Agree or Disagree**) to the implementation of the Vaccine. (※ Please circle either of Agree or Disagree in the parenthesis.) In case of disagree, vaccination will not be made. Understanding that this questionnaire is to secure the safety of vaccination, I agree that it will be submitted to Chiba City.

**Signature of parent/guardian or the representative.**

(注) ガンマグロブリンは、血液製剤の一種で、A型肝炎などの感染症の予防目的や重症の感染症の治療目的などで注射されることがあり、この注射を3～6カ月以内に受けた方は、麻疹などの予防接種の効果が出ないことがあります  
Remark: Gamma Globulin is a blood product to be injected for prevention of infection diseases like Hepatitis A and for treatment of serious infection diseases. There are cases that vaccination of measles etc., may not be effective for those people who received Gamma Globulin injection in the past 3 to 6 months

..... DT (ジフテリア・破傷風)予防接種 (医療機関控用)

1. 生年月日 年 月 日

2. 住所 千葉市 区

3. 接種年月日 年 月 日      メーカー名      Lot No.

If

Record of DT (Diphtheria・Tetanus) (for records of Medical institution)

1. Name of the inoculated person: ( )      Date of Birth:

2. Address :

3. Date of inoculation :      Manufacturer      Lot No.

## DT: Diphtheria Tetanus

### **【Explanation of the disease】**

#### **((Diphtheria: D))**

Infection of Diphtheria is caused by the droplets of the diphtheria bacillus enter through nose and mouth. However, only about 10% people show diphtheria symptom. Remainders become quiet germ holders, who might spread the germ to other people

The symptoms are high temperature, throat pain and strong inflammations. The myocardial failure and nerve paralysis might be caused by the toxin that the bacterium puts out. Incidence rate of diphtheria is 0 to 1 person per year.

#### **((Tetanus: T))**

Infection is caused by tetanus bacillus in the soil entering into human body through wounds. As the number of bacteria increases in the body, muscle twitching is caused by the toxin generated by the germ. The disease is noticed first by the difficulty to open the mouth and it develops to the convulsion of the whole body. There is a possibility that a patient may die if treatment is delayed. Infection of more than half of the patients are via very minor stabs which they did not notice.,

#### **【Sub-reactions】**

The major sub-reactions are the reddishness, swelling, and stiffness of the inoculated area. In rare cases, shock, anaphylactic symptoms, thrombocytopenic purpura, encephalopathy, and the convulsion may appear.

#### **【Those who cannot inoculated】**

- ① Children who apparently have a fever (over 37.5°C)
- ② Children who got a serious acute disease.
- ③ Child who had caused anaphylaxis by the contents in vaccination liquid of the vaccination received on that day
- ④ Additionally, those who are judged by the doctor that inoculation is inappropriate.

#### **【Children who need consultation with the doctor before inoculation】**

- ① Children who are being treated for diseases like heart disease, kidney disease, blood diseases, growth disturbance etc.
- ② Children who experienced allergenic reactions like high temperature, whole body eruptions within two days after vaccination
- ③ Children who have caused convulsion in the past.
- ④ Children who have been diagnosed as immunodeficient and those who have a close relative with congenital immunodeficiency.
- ⑤ Children who were told allergenic to the contents of vaccine, which contains contents of eggs used to culture, antibiotics, stabilizer etc.
- ⑥ Children in good conditions, while diseases like measles, rubella, mumps, and chicken poxes, are spread among family members, play mates, class mates, etc.

#### **【General notes after inoculation】**

- ① As acute sub-reactions may happen, please watch the condition of your child for 30 minutes in the medical institute or to make sure of immediate contact with your home doctor.
- ② In case of an inactivated vaccine, please be careful about sub-reaction for a week
- ③ Keep the inoculated area clean. It is OK to take bath, however, do not rub the inoculated area.
- ④ Avoid vigorous exercises on the day of inoculation.
- ⑤ if you noticed abnormal reactions around the inoculated area or change of body conditions, please visit home doctor and have your child examined.

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#### About Health Injury Relief System:

If you have symptoms like heavy swelling of the inoculated area, high fever, convulsion, etc., please get examined by your family doctor and contact Infection Prevention Section. There might be a possibility that your case might be recognized by Health Injury Relief System under The Preventive Vaccination Law.