*If you desire to be vaccinated, fill in the boxes below:

Screening Questionnaire for Rabies Vaccination (Rabipur for intramascular injection)

			Body temperature before interview	℃
Number of Doses	First/Second/Third/ th times, Last Vaccination Date: / / (dd/mm/yy)			
Address			TEL No.	
Patient's Name		M F	Birth Date	/ / (dd/mm/yy) Age (years months)

Questionnaire for Vaccination	Answer		Doctor's Comment
Have you read and understood the explanation about the vaccination that will be administered today?	No	Yes	
Do you currently have any sort of illness? Are you feeling sick today?	Yes If so, please describe in detail. ( )	No	
Are you receiving any treatment (e.g., medicines) for the illness?	Yes Name/type of the medicine ( )	No	
Have you been ill in the past month?	Yes Disease name ( )	No	
Do you have a health problem with heart disease, kidney disease, liver disease, hematologic disease, immune deficiency, or others for which you have consulted a doctor?	Yes Disease name ( )	No	
Where relevant, did the doctor who manages the above disease agree with today's vaccination?	No	Yes	
(If the vaccination is for a child) Were there any problems with the child's health at delivery, after birth, or at infant health check?	Yes Describe in specific ( )	No	
Have you ever had a seizure (spasm or fit) in the past?	Yes At ( ) years old	No	
Did you have a fever at that time?	Yes		
Have you ever had a rash or urticaria (hives or 'nettle rash') as a reaction to medications or food, or become ill after eating certain foods or receiving certain medications?	Yes Food or medication name ( )	No	
Have you ever experienced a decreased blood pressure, shock or anaphylaxis (allergic reaction that usually develops within 30 min after vaccination associating with breathing difficulty and/or generalized hives) to medicines or food containing gelatin?	Yes	No	
Have any of your family members or relatives had a serious reaction to a vaccine in the past?	Yes Vaccine name ( )	No	
Do you have a family member or relative with a congenital immunodeficiency?	Yes	No	
Have any of your family or anyone around you contracted measles, rubella, chickenpox, or mumps in the past month?	Yes Disease name ( )	No	
Have you been vaccinated in the past month?	Yes Vaccine name ( ) Date administered: / (dd/mm)	No	
Have you had a serious reaction to a vaccine in the past?	Yes Vaccine name ( )	No	
(Women only) Are you pregnant or possibly pregnant?	Yes	No	
Do you have any questions about today's vaccination?	Yes Describe in specific ( )	No	

Doctor's Comment

Based on the above answers and the results of interview, I have decided that the patient (can / should not) receive a vaccination today.
I have explained to the patient (or the guardians) the information concerning the benefits and side effects of vaccination as well as the Relief System for Sufferers from Adverse Drug Reactions.

Signature or Name and Seal of Doctor: _____

Having interviewed and explained by the doctor, do you wish to receive a vaccination with the understanding of the benefits and side effects of vaccination and the Relief System for Sufferers from Adverse Drug Reactions?

Yes / No

Signature of the Patient or Proxy _____

If proxy signs, describe relationship _____

Vaccine Name	Vaccination Site, Dosage, and Administration	Institution, Doctor Name, Date Administered
Rabipur Inactivated Rabies Virus Vaccine GlaxoSmithKline K.K. Lot No.:	Intramuscular injection,1.0 ML (R / L)	Institution Doctor Name Date / / (dd/mm/yy) Administered At : am /pm

This screening questionnaire is used to ensure the safety of vaccination. The personal information described here will be used only for screening for vaccination.

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