Name: X Date of Birth: XX/XX/XX Sex: X

Tuberculin Reaction and BCG Vaccination

Test Date Y/M/D	Injection Site	Physician's Sign	Reaction	Result	Sign of Person Judged	BCG Vaccination Y/M/D	Physician's Sign

Pertussis, Diphtheria, tetanus

Tim		Immunization Date Y/M/D	Type of Vaccine	Lot No (Amount)	Physician's Sign
First Time	I				
	II				
	III				

Poliomyelitis (Polio)

Time	Immunization Date Y/M/D	Lot No	Remarks	Physician's Sign
First Time				
Second Time				

Measles, Mumps, and Rubella

Immunization Date Y/M/D	Lot No	Remarks	Physician's Sign

Other Vaccinations

Vaccine	Immunization Date Y/M/D	Lot No	Amount of Intake	Remarks	Physician's Sign
Japanese Encephalitis					
Japanese Encephalitis					
Japanese Encephalitis					