

CHILD'S HEALTH REPORT <FORM 3 : 様式 3>

Fill-in Date: / /

Name of the child :

Date of birth :

YYYY / MM / DD

Age: _____ year(s) and _____ months old
(as of fill-in date)

Please be sure to provide accurate and detailed information about your child's health status, as this information is very important for the admission process. Admission may be revoked if it is found that the information on the application is insufficient, untrue or falsified.

⇒ ☐ **I agree** (Please check if you agree)

※Please contact the Nursery School Admissions Office (047-366-7351) anytime if there are any changes to your child's health condition

Place a check✓ next to all applicable items and provide specifics in parentheses () for the following.

Birth Conditions	Condition at birth	<input type="checkbox"/> Normal <input type="checkbox"/> Premature <input type="checkbox"/> Incubation <input type="checkbox"/> Asphyxia <input type="checkbox"/> Other ()		
	•Weight at birth () g •Current weight () kg •Current height () cm			
	•Gestation period () weeks •Baby's condition	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal⇒Diagnosis ()		
	Type of nutrition	<input type="checkbox"/> Breast milk <input type="checkbox"/> Mix <input type="checkbox"/> Baby formula <input type="checkbox"/> Baby food (times/day: stage 1・2・3) <input type="checkbox"/> Regular food		
Health Condition	When was the first time your child was able to do these actions?	•Held his/her head steady (at mo. old / not yet) •Sat without support (at mo. old / not yet) •Crawling (at mo. old / not yet) •Pulled him/her-self up (at mo. old / not yet) •Walking (at mo. old / not yet)		
	Health checkups received	<input type="checkbox"/> 1 mo. <input type="checkbox"/> 3-4mo. <input type="checkbox"/> 6-7mo. <input type="checkbox"/> 9-10mo. <input type="checkbox"/> 1yr. <input type="checkbox"/> 18mo. <input type="checkbox"/> 3yr.		
	Record of health checkups	<input type="checkbox"/> No problem <input type="checkbox"/> Point noted/observation-needed (describe what was noted and when) ()		
	Any congenital/chronic diseases, or developmental counseling	<input type="checkbox"/> No	<input type="checkbox"/> Yes ⇒ What (), Name of medical facility () Treatment receiving (), Point of concern (None / Yes:) Medication (Yes / No), Frequency of clinic visit (times/week・month・year)	
	Any major illnesses or injuries	<input type="checkbox"/> No	<input type="checkbox"/> Yes ⇒ When? (at yr, mo. old) Disease/injury name () Name of medical facility (), Matters to be considered (None / Yes:)	
	Any allergies, etc.	<input type="checkbox"/> No	<input type="checkbox"/> Yes ⇒ Allergy type () Note: Use of EpiPen / Asthma / Atopy / Other ()	
	Any convulsions or seizures	<input type="checkbox"/> No	<input type="checkbox"/> Yes ⇒ (times), (at yr. mo. old), Cause ()	
	Has a Disability or Rehabilitation Certificate, etc.	<input type="checkbox"/> No	<input type="checkbox"/> Yes ⇒ Rehabilitation (grade:) / Physical (grade:) / Daycare Beneficiary Certificate / Certified recipient of Special Childrearing Allowance	
Immunizations	Check box for completed vaccinations			
	<input type="checkbox"/> Hib (Haemophilis Influenzae type B) <input type="checkbox"/> Infant Pneumococcus <input type="checkbox"/> Rota <input type="checkbox"/> D P T - I P V (Diphtheria-Pertussis-Tetanus-Imovax Polio) <input type="checkbox"/> Japanese Encephalitis 1st term <input type="checkbox"/> Hepatitis B <input type="checkbox"/> B C G <input type="checkbox"/> Chicken Pox <input type="checkbox"/> MR (Measles & Rubella) 1st term <input type="checkbox"/> Mumps <input type="checkbox"/> MR (Measles & Rubella) 2nd term			
Development	Circle Yes or No for each point below to answer whether it applies to your child		0 - 1 yr old graders	2- 5 yr. old graders
	① Does your child laugh out loud?		Yes・No	Yes・No
	② Does your child respond or look around when called?		Yes・No	Yes・No
	③ Does your child point to the thing he/she wants?		Yes・No	Yes・No
	④ Does your child understand simple words (i.e. "come here" and "give me", etc.) from the adults?		Yes・No	Yes・No
	⑤ Does your child say at least 3 different words that have a meaning? (i.e. "mommy" and "yum-yum", etc.)		Yes・No	Yes・No
	⑥ Can your child understand and follow simple commands, such as "get me ○○", etc.?		Yes・No	Yes・No
	⑦ Does your child speak 2-word sentences? (i.e. "Puppy came" and "I'm hungry", etc.)		Yes・No	Yes・No
	⑧ Does your child use (or try to use) a spoon/chopsticks to feed him/her-self?		Yes・No	Yes・No
	⑨ Has your child troubled you with his/her stubbornness, tantrums, and/or screams?		No・Yes	No・Yes
	⑩ Do you have any concerns for your child upon living in a group/communal living?		No・Yes	No・Yes
	⑪ Does your child tell (or try to tell) you what they have experienced?			Yes・No
	⑫ Can your child play following rules and keeping promises?			Yes・No
	⑬ Has your child troubled you because he/she is restless, moving around and cannot stay in one place, forcing you to keep an eye on them constantly?			No・Yes
※ If you answered "Yes" to any of ⑨, ⑩, and/or ⑬ above, please describe in detail.				

※Depending on your child's situation, we may also ask you to submit a Child Health Questionnaire (Form 3-2)