Date of entry (yyyy/mm/dd): **Child Record** $2 \cdot 3 \cdot 4 \cdot$ • 1 • Katakana Katakana Guardian В Name Child Physician : TEL Family Name Birth date(yyyy/mm/dd) Surgery: G Doctor Dentistry: (〒 Please list in order of priority contacts Relationship Current **(1)** Address (2) 3 Katakana Family Workplace/School Relation Date of Birth Phone number Name ship Situation Family ①Name ②Name ③Name **Emergency Contact Priority** Phone: Phone: Phone: Other than Parents Sent by (name) Time Pick up by (name) Pick up by (name) Time seeing off Time Sat. and meeting Name of business where relationship/name Name of business where relationship/name parent/guardian works parent/guardian works Start Time : Start Time **End Time** End Time Parent's Saturday work Parent's Saturday work schedule schedule about min. Time from facility to work Time from facility to work about min. ☐ No Saturday use How long do you **Short Period** ☐ Use until 12:00 pm on Sat. *Check one of the require childcare? 8:30~16:30 appropriate boxes \square Use after 12:00 pm on Sat. one as application documents! ☐ No Saturday use ※As a general rule, it is

Long Period

7:30~18:30

Use until 12:00 pm on Sat.

☐ Use after 12:00 pm on Sat.

*Check one of the

appropriate boxes

determined by the working

hours and commuting time

of the parents.

Developmental status and medical history									
1	When was your child's head stable?	() r	nonth · No		Have you been diagonatopy/allergy?	nosed with	Yes※	No	
2	When did your child start walking alone?	() month · No			**Those who answered "Yes" [Allergy Test Result→□Yes □No]				
3	When did your child start speaking meaningful	()month·No			● Foods to be restricted □ Egg □ Wheat □ Dairy products □ Others 《 》				
4	words (mama, papa, wan wan, etc.)? When you call your child, does he/she react?	Yes	No		own lunches.)	provide safe lunc	hes, we may ask fam	ilies to bring their	
5	Can you make eye contact with your child?	Yes	No	18	● Others □ Bronchial asthma	□Atopic derm	atitis	tis(hay fever)	
6	Does your child look for or cry when he/she can not see the person who is usually with him/her?	Yes	No		□Allergic conjunctiv □その他(vitis(hay fever)	□Animal allergy □	Drug allergy	
7	Can your child understand simple instructions (come here, wait for me, no, etc.)?	Yes	No		▼ <u>Please describe yo</u>	our symptoms.	•	,	
8	Does your child try to communicate by pointing?	Yes	No						
9	Does your child enjoy being with friends?	Yes	No		Has your child been a doctor that he/she		Yes ()years old	No	
10	Does your child suddenly and without reason slap, bite, or raise a loud voice?	Yes	No		4type VACC: (1回・		ccinations Streptococcus	oneumoniae :	
11	Does your child stick to the limited things (numbers, shapes, play, food or etc.)?	Yes	No		B C G : (1回) Japanese encephalit	tis ·	•	3 回·Additional) · 3回 · Additional)	
12	Does your child have an aversion to being touched by others or to noises?	Yes	No			2回・3回・4回)	,)	
13	Does your child have trouble with sleep; shallow sleep, difficulty falling asleep, or sleeping only for short periods of	Yes	No	19	Measles II期:(1	. 🗇)	Rotavirus ()	
	Has your child had any major illnesses or injury in the past? (infection, heart disease, head injury, broken bones, etc.)	Yes	No		Rubella I期:(1[Rubella II期:(1[Chicken pox :(1	(a)	Influenza(Others ()	
14	Name of illness or injury ()					Major Medical Hhistory			
	Hospital Name()				Measles (hicken Pox (歳)	
				20	Meningitis (Pertussis (歳) Ka	Aumps (awasaki disease (歳)	
	Persons under treatment or observation: Have you consulted with your doctor			@ DI	Rubella (neumonia (歳)	
	regarding admission? □Yes □No Has your child had Cramps and Convulsions Yes No			© Pi	Please fill in below as much as you know by referring to the Maternal Handbook Circumstances of birth				
15	before?						· Suction · Asphyxia		
	(y m old, body temparature is about and times)			23	Height and Weight at birth \rightarrow Height()cm Weight () g				
	Medication				The baby was born at ()weeks gestation. • Unkown • Please answer if you are applying for admission in the 0- or 1-year-old class.				
	For developmental or chronic illness, is your child currently going to a hospital or receiving Yes No			25	Progress of baby for	11 , 3	admission in the 0- or	1-year-old class.	
	Name of disease / disability ()			25		,	□Late □Completion	□End	
	Name of hospital or facility()				Can the baby drink l		Yes	Breast Milk Only	
	Current Situation □Healing □During treatment □Observation						t advice you received ou discussed about y		
	Medication □No □Yes (times day)			4-m	nonth-old check-up	<u> </u>	<u> </u>		
	Have you consulted with your doctor/consultant regarding admission? □Yes □No				Receive □Not				
				1 ye	ar&6 month check-up				
					Receive □Not				
	Please describe your child's personality and any special attention you would like us to pay.				ars & 6 month check-up				
17	(e.g.) "Shy," "arms easily slip out," etc.				Receive Not You have a Physical D	Disability Certific	ate		
					or Rehabilitation Cert	tificate HB?	Yes	No	
					ose who answered	"Yes"⇒Handb	ook Name, Grade,	Degree	