

Child Status Report

2026

For all items, please fill in your daily living situation.

Applying child (1)		Edogawa Kisaku		Applying child (2)		Edogawa Akabei	
Gender		<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female		Gender		<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	
Current height (<input type="text"/> <input type="text"/>) cm, weight (<input type="text"/> <input type="text"/>) kg				Current height (<input type="text"/> <input type="text"/>) cm, weight (<input type="text"/> <input type="text"/>) kg			
How many weeks into the pregnancy were they born?		(<input type="text"/> <input type="text"/>) weeks (<input type="text"/> <input type="text"/>) days		(<input type="text"/> <input type="text"/>) weeks (<input type="text"/> <input type="text"/>) days			
Circumstances at birth		<input checked="" type="checkbox"/> Normal <input type="checkbox"/> Cesarean section <input type="checkbox"/> Vacuum extraction <input type="checkbox"/> Suspended animation		<input type="checkbox"/> Normal <input checked="" type="checkbox"/> Cesarean section <input type="checkbox"/> Vacuum extraction <input type="checkbox"/> Suspended animation			
Height and weight at birth		Height (<input type="text"/> <input type="text"/>) cm, weight (<input type="text"/> <input type="text"/>) g		Height (<input type="text"/> <input type="text"/>) cm, weight (<input type="text"/> <input type="text"/>) g			
Are you currently visiting or consulting with a hospital or facility about a chronic illness or other problem they have?		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
(1) Name of disease (<input type="text"/>)				(1) Name of disease (<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>)			
(2) Hospital (<input type="text"/>)				(2) Hospital (<input type="text"/> <input type="text"/> Hospital)			
Have they had any major illnesses in the past?		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
(1) Name of disease (<input type="text"/>)				(1) Name of disease (<input type="text"/>)			
(2) Hospital (<input type="text"/>)				(2) Hospital (<input type="text"/>)			
Have they ever had convulsions or seizures?		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
At about (<input type="text"/>) years (<input type="text"/>) months old with a temperature of (<input type="text"/>) about (<input type="text"/>) times				At about (<input type="text"/> 1) years (<input type="text"/> 3) months old with a temperature of (<input type="text"/> 39.1) about (<input type="text"/> 1) times			
Have they ever had an anaphylactic reaction?		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
Do they have any food allergies?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Food (<input type="text"/>)				Food (<input type="text"/> Shrimp)			
Do they have any non-food allergies?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Type of allergy (<input type="text"/>)				Type of allergy (<input type="text"/> House dust)			
Are there any foods that they cannot have due to religious reasons, illness, etc.?		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Food (<input type="text"/>)				Food (<input type="text"/>)			
Do they take any oral medications?		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
*If they have been prescribed an EpiPen, please fill out this section.				① <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner *Check if applied <input checked="" type="checkbox"/>			
② Medicine name (<input type="text"/> Magnesium oxide)				② Medicine name (<input type="text"/>)			
At what age could the child hold up his/her head?		At around (<input type="text"/> 3) months <input type="checkbox"/> Not yet		At around (<input type="text"/>) months <input type="checkbox"/> Not yet			
When did they start walking (walking on their own)?		At around (<input type="text"/> 12) months <input type="checkbox"/> Not yet		At around (<input type="text"/>) months <input type="checkbox"/> Not yet			
When did they start to communicate by pointing?		At around (<input type="text"/> 14) months <input type="checkbox"/> Not yet		At around (<input type="text"/>) months <input type="checkbox"/> Not yet			
Do you have any concerns about their hearing?		<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
Do they make eye contact?		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
Can they understand simple words that adults say (such as "come" and "please")?		Yes <input checked="" type="checkbox"/> Japanese <input type="checkbox"/> Other than Japanese <input type="checkbox"/> Not yet		Yes <input checked="" type="checkbox"/> Japanese <input type="checkbox"/> Other than Japanese <input type="checkbox"/> Not yet			
Can they say two-word sentences (give me, dog came, etc.)?		Yes <input checked="" type="checkbox"/> Japanese <input type="checkbox"/> Other than Japanese <input type="checkbox"/> Not yet		Yes <input type="checkbox"/> Japanese <input type="checkbox"/> Other than Japanese <input checked="" type="checkbox"/> Not yet			
Can they say their own name?		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> Not yet		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> Not yet			
Fill in only if aged 3 or older	Does he/she hit, bite, or make strange noises?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No			
	Is it hard for him/her to sit still in one place/do they move around restlessly?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No			
	Does he/she climb or jump up suddenly?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No			
Are there any hospitals or facilities that you are currently visiting, consulting with, or thinking about consulting with regarding their speech or development?		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
① <input type="checkbox"/> Visiting <input type="checkbox"/> Consultation *Check one <input checked="" type="checkbox"/>				① <input type="checkbox"/> Visiting <input checked="" type="checkbox"/> Consultation *Check one <input checked="" type="checkbox"/>			
⇒Contents (<input type="text"/>)				⇒Contents (<input type="text"/> speech delay)			
②Please check (fill in) <input checked="" type="checkbox"/> one of the following.				②Please check (fill in) <input checked="" type="checkbox"/> one of the following.			
<input type="checkbox"/> Health Support Center (Komatsugawa, Tobu, Shishibone, Chuo, Koiwa, Seishincho, Kasai, Nagisa)				<input type="checkbox"/> Health Support Center (Komatsugawa, Tobu, Shishibone, Chuo, Koiwa, Seishincho, Kasai, Nagisa)			
<input type="checkbox"/> Development Consultation & Support Center (Nanairo)				<input type="checkbox"/> Development Consultation & Support Center (Nanairo)			
<input type="checkbox"/> Child Development Support Center (Kasai, Shinozaki, Koiwa)				<input checked="" type="checkbox"/> Child Development Support Center (Kasai, Shinozaki, Koiwa)			
<input type="checkbox"/> Shikamoto Rearing Room				<input type="checkbox"/> Shikamoto Rearing Room			
<input type="checkbox"/> Other (<input type="text"/>)				<input type="checkbox"/> Other (<input type="text"/>)			
Do they have a disability certificate or Ai-no-Techo (certificate of the intellectually disabled)?		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Disability certificate (<input type="text"/>) Grade				Disability certificate (<input type="text"/>) Grade			
Ai-no-Techo (Certificate of the Intellectually Disabled Degrees)				Ai-no-Techo (Certificate of the Intellectually Disabled Degrees)			
Do you have any concerns about the health and development of your child as they enter nursery school?		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
→If "Yes", please specify.				→If "Yes", please specify. The doctor told me at a regular checkup that they were behind in speech.			

If you are unsure if they are allergic to any of the following, check "Unknown". If they have an allergy, check "Yes" and indicate the type of allergy.

If you are consulting about their speech or development, please also fill in ① and ②.