

# Child Status Report

2026

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

		Applying child (1)		Applying child (2)	
		Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
		Current height ( ) cm, weight ( ) kg		Current height ( ) cm, weight ( ) kg	
How many weeks into the pregnancy were they born?		( ) weeks ( ) days		( ) weeks ( ) days	
Circumstances at birth		<input type="checkbox"/> Normal <input type="checkbox"/> Cesarean section <input type="checkbox"/> Vacuum extraction <input type="checkbox"/> Suspended animation		<input type="checkbox"/> Normal <input type="checkbox"/> Cesarean section <input type="checkbox"/> Vacuum extraction <input type="checkbox"/> Suspended animation	
Height and weight at birth		Height ( ) cm, weight ( ) g		Height ( ) cm, weight ( ) 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 type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		(1) Name of disease ( )		(1) Name of disease ( )	
		(2) Hospital ( )		(2) Hospital ( )	
Have they had any major illnesses in the past?		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		(1) Name of disease ( )		(1) Name of disease ( )	
		(2) Hospital ( )		(2) Hospital ( )	
Have they ever had convulsions or seizures?		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		At about ( ) years ( ) months old with a temperature of ( ) about ( ) times		At about ( ) years ( ) months old with a temperature of ( ) about ( ) times	
Have they ever had an anaphylactic reaction?		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do they have any food allergies?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
		Food ( )		Food ( )	
Do they have any non-food allergies?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
		Type of allergy ( )		Type of allergy ( )	
Are there any foods that they cannot have due to religious reasons, illness, etc.?		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		Food ( )		Food ( )	
Do they take any oral medications?		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input 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"/>		① <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner *Check if applied <input checked="" type="checkbox"/>	
		② Medicine name ( )		② Medicine name ( )	
At what age could the child hold up his/her head?		At around ( ) months <input type="checkbox"/> Not yet		At around ( ) months <input type="checkbox"/> Not yet	
When did they start walking (walking on their own)?		At around ( ) months <input type="checkbox"/> Not yet		At around ( ) months <input type="checkbox"/> Not yet	
When did they start to communicate by pointing?		At around ( ) months <input type="checkbox"/> Not yet		At around ( ) months <input type="checkbox"/> Not yet	
Do you have any concerns about their hearing?		<input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> No <input type="checkbox"/> Yes	
Do they make eye contact?		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Can they understand simple words that adults say (such as "come" and "please")?		Yes <input 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 type="checkbox"/> Not yet	
Can they say two-word sentences (give me, dog came, etc.)?		Yes <input 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 type="checkbox"/> Not yet	
Can they say their own name?		<input type="checkbox"/> Yes <input type="checkbox"/> Not yet		<input 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 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 type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Does he/she climb or jump up suddenly?	<input type="checkbox"/> Yes <input 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 type="checkbox"/> No		<input 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 type="checkbox"/> Consultation *Check one <input checked="" type="checkbox"/>	
		⇒Contents ( )		⇒Contents ( )	
		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 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="checkbox"/> Other ( )	
Do they have a disability certificate or Ai-no-Techo (certificate of the intellectually disabled)?		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		Disability certificate ( ) Grade		Disability certificate ( ) 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 type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		→If "Yes", please specify.		→If "Yes", please specify.	

\*After submission, we may ask for further interviews and documents depending on the situation of the child.