

# Child Status Report

2027

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

| Name of Child Applicant (1)                                                                                                                                      |                                                                                  | Name of Child Applicant (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                                                                                                                                              |                                                               |
| Circumstances at birth                                                                                                                                           |                                                                                  | <input type="checkbox"/> Normal <input type="checkbox"/> Cesarean section <input type="checkbox"/> Vacuum extraction <input type="checkbox"/> Neonatal asphyxia |                                                               |
| Height and weight at birth                                                                                                                                       |                                                                                  | 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                                                                                                        |                                                               |
| (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                                                                                                        |                                                               |
| (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                                                                                                        |                                                               |
| At about ( ) years ( ) months old with a temperature of ( ) °C about ( ) times                                                                                   |                                                                                  | At about ( ) years ( ) months old with a temperature of ( ) °C about ( ) times                                                                                  |                                                               |
| Have they ever had an anaphylactic reaction?                                                                                                                     |                                                                                  | <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                                                                       |                                                               |
| Food ( )                                                                                                                                                         |                                                                                  | Food ( )                                                                                                                                                        |                                                               |
| Do they have any non-food allergies?                                                                                                                             |                                                                                  | <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                                                                                                        |                                                               |
| Food ( )                                                                                                                                                         |                                                                                  | Food ( )                                                                                                                                                        |                                                               |
| Do they take any oral medications?                                                                                                                               |                                                                                  | <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"/>       |                                                               |
| ② Medicine name ( )                                                                                                                                              |                                                                                  | ② Medicine name ( )                                                                                                                                             |                                                               |
| When did they start holding up his/her head?                                                                                                                     |                                                                                  | 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                                                                                                           |                                                               |
| When did they start communicating by pointing?                                                                                                                   |                                                                                  | At around ( ) months <input type="checkbox"/> Not yet                                                                                                           |                                                               |
| Do you have any concerns about their hearing?                                                                                                                    |                                                                                  | <input type="checkbox"/> No <input type="checkbox"/> Yes                                                                                                        |                                                               |
| Do they make eye contact?                                                                                                                                        |                                                                                  | <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                                             |                                                               |
| 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                                             |                                                               |
| Can they say their own name?                                                                                                                                     |                                                                                  | <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                                                                                                        |                                                               |
|                                                                                                                                                                  | 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                                                                                                        |                                                               |
|                                                                                                                                                                  | Does he/she climb or jump up suddenly?                                           | <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                                                                                                        |                                                               |
| 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 (Nanaïro)                                                                                     |                                                                                  | <input type="checkbox"/> Development Consultation & Support Center (Nanaïro)                                                                                    |                                                               |
| <input type="checkbox"/> Child Development Support Center (Kasai, Shinozaki, Koiwa)                                                                              |                                                                                  | <input type="checkbox"/> Child Development Support Center (Kasai, Shinozaki, Koiwa)                                                                             |                                                               |
| <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                                                                                                        |                                                               |
| 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                                                                                                        |                                                               |
| →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.