Health Inquiry Sheet

Please fill out this sheet completely. This sheet will be used for your child's health and safety at school during needed medical check-ups. The data on this sheet is confidential, but in case of an emergency, we may provide information to rescue crews (i.e. Fire officers).

Grade:_____Class:_____ No:_____ (M • F)		Present address	
Child's name		Guardian's name	
Date of birth	Year/Month/Day	Phone number	

Emergency Contact Person

1st contact person	Name		Relationship	Mobile phone: Workplace ( ) TEL:
2nd contact person	Name		Relationship	Mobile phone: Workplace ( ) TEL:
3rd contact person	Name		Relationship	Mobile phone: Workplace ( ) TEL:

Members of the Family

Name	Relationship	Name	Relationship	Name	Relationship

Allergic Reactions (Yes • No)

Name of Medicine /Food	Allergic reaction (Circle all that apply)	How to treat (Circle if any)
	1. Inflamed skin 2. Itchy throat 3. Difficulty in breathing 4. Feel sick 5. Others ( )	1. Observe and take needed action 2. Take to the hospital 3. Treatment ( )

★At home how does your child deal with the allergic causing food?

① Can eat small amounts of allergic food ② Remove allergic causing food before eating

③ Do not use allergic causing food

Has your child ever had an anaphylactic shock? Yes • No

※If yes • • • (since years old) Cause ( )

※EpiPen prescription Yes • No Family doctor ( )

Present Health Condition (Normal body temperature: ℃)

Prone to headache	Yes • No	Have allergic conjunctivitis	Yes • No
Prone to stomachache	Yes • No	Have allergic rhinitis	Yes • No
Hearing difficulty	Yes • No	Have atopic dermatitis	Yes • No
Others	Symptom:		

Present Physical Condition (Check your child and circle all that apply)

① A difference in the height of shoulders when standing or level of shoulders blades when bending.

② A pain when the waist is stretched on bent.

③ A pain in knees or/and elbows when bending or stretching.

④ Cannot raise both arms above the head and touch the ears with the arms.

⑤ Cannot stand on one leg more than 5 seconds.

⑥ Cannot squat.

Present Medical Treatment Yes • No (Name of disease;)

If your child received any treatment or check-ups at the hospital, please describe it.

Disease name	Diagnosis age	Present condition	Movement restrictions
Asthma	Age	• Cured • Undergoing treatment Medicine : Yes • No • Follow up • Regularly go to hospital every ( ) months	Yes • No ( )
Epilepsy	Age	• Cured • Undergoing treatment Medicine : Yes • No • Follow up • Regularly go to hospital every ( ) months	Yes • No ( )
Heart disease ( )	Age	• Cured • Undergoing treatment Medicine : Yes • No • Follow up • Regularly go to hospital every ( ) months	Yes • No ( )
Kidney disease ( )	Age	• Cured • Undergoing treatment Medicine : Yes • No • Follow up • Regularly go to hospital every ( ) months	Yes • No ( )
Otitis media	Age	• Cured • Undergoing treatment Medicine : Yes • No • Follow up • Regularly go to hospital every ( ) months	Yes • No ( )
Kawasaki disease	Age	• Cured • Undergoing treatment Medicine : Yes • No • Follow up • Regularly go to hospital every ( ) months	Yes • No ( )
Others ( )	Age	• Cured • Undergoing treatment Medicine : Yes • No • Follow up • Regularly go to hospital every ( ) months	Yes • No ( )

Special Care at School

Disease name		Family doctor ( ) Diagnosis age (years old)
Special care at school: Symptoms and how to treat during an attack. (Exercise limitation, Diet restriction, Medication, Others)		

Record of Childhood Illnesses, Infections, Vaccinations, and Others (Circle all that apply)

Infection disease	Condition	Infection disease	Condition	Injury, Accidents, Surgery
Measles	Infected Yes • No	Chicken pox	Age ( ) Immunized: Yes • No	Injury • Accident • Surgery Age ( ) Part of body injured ( )
Rubella	Infected Yes • No			
Immunize Vaccination	MR: Yes (1 • 2 times) • No			
	Measles: Yes (1 • 2 times) No			
	Rubella: Yes (1 • 2 times) No	Mumps	Age ( ) Immunized: Yes • No	Present influence ( )

Tuberculosis (Please circle your answer)

Has your child suffered from Tuberculosis (T.B.) disease in the past two years?		Yes • No
Has your child taken preventive medicine for being infected with T.B. in the past two years?		Yes • No
Had anyone in your family been infected with T.B.?		Yes (year month) • No
Has your child lived in any foreign country more than six months in total in the past three years?		Yes • No (Country:)
	If yes: Did your child receive a detailed examination after coming to Japan? ＊Need an examination if been in infectious country	Yes • No
Has your child had symptoms of coughing and phlegm in the past two weeks?		Yes • No
If yes	Has your child received treatment or medical examination?	Yes • No
	Has your child ever been diagnosed with asthma or bronchial asthma?	Yes • No

BCG (Tuberculosis prevention) Immunized	Yes No Reason: