

## 健康調査票 Health Survey

(Parents/guardians must fill out the form in advance and bring it with them on the day of the event.)

furigana Child's name				gender M • F		<b>If you have concerns about your child's physical/mental health or behavior like the following, please circle the number.</b> 1. needs assistance with dressing and undressing. 2. may not follow my instructions or repeat the same thing even after instructed so many times. 3. Sometimes looks like daydreaming/doing nothing. 4. may lose temper over trivial things. 5. cannot concentrate for a long time. 6. cannot sit still and moves around a lot. 7. often becomes too enthusiastic about one thing or focus on what s/he likes too much. 8. Does not show interest in letters or numbers. 9. There are things that worry me in terms of language development (pronunciation, the way of speaking, lack of words) 10. rarely interact with friends and often plays by him/herself. 11. may not be able to act in a group and may act as s/he wishes. 12. The way s/he uses hands and feet can be awkward. 13. I have concerns about my child's hearing ability. 14. I have concerns about my child's eyesight. 15. has had a seizure/spasm before. (Circle an applicable symptom - a febrile convulsion -Other) 16. has food allergies. If there is anything you think the school should know or anything you are worried about, write it down here.	
Date of birth	年 YYYY 月 MM 日 DD						
Parent's name			TEL				
Postal address							
History of illness (Put a circle on the applicable section)	Heart disease		Kidney disease				
	Asthma		Liver disease				
	Describe other illness(es) your child has ever had.						
History of vaccination /infection (Put a circle on the applicable section)	Name of vaccination	Vaccinated	Infected	Name of vaccination	Vaccinated	Infected	
	Haemophilus influenzae type B			Chicken pox			
	Pneumococcal infection			Japanese encephalitis	1st stage	additional	
	Hepatitis B				1st 2nd		
	DPT-IPV (Diphtheria/Pertussis/Tetanus/Polio)			Mumps			
	BCG (Tuberculosis)			Provide other vaccination if any (except for influenza).			
Measles/Rubella	1st	2nd	Measles				
			Rubella				

※No need to fill out the following part

## 就学時健康診断票

医師使用欄				健康診断 年月日	年 月 日
栄養状態	良好・要注意	眼の疾病及び異常	なし・あり	う	永久歯 <input type="checkbox"/> なし <input type="checkbox"/> 処置済み <input type="checkbox"/> あり
肥満傾向	なし・あり	耳鼻咽喉頭疾患	なし・あり	歯	乳歯 <input type="checkbox"/> なし <input type="checkbox"/> 処置済み2本以下 <input type="checkbox"/> あり <input type="checkbox"/> 処置済み3本以上
脊柱の異常	なし・あり			要観察歯 (C0)	<input type="checkbox"/> なし <input type="checkbox"/> あり
胸郭の異常	なし・あり	視力	右 ( )	むし歯になりやすい傾向	<input type="checkbox"/> なし <input type="checkbox"/> あり <input type="checkbox"/> 当日の指導 <input type="checkbox"/> 地域の歯科医へ要相
皮膚疾患	なし・あり		左 ( )	口腔の疾病及び異常	<input type="checkbox"/> なし <input type="checkbox"/> あり <input type="checkbox"/> 不正咬合 <input type="checkbox"/> 要注意乳歯 <input type="checkbox"/> 歯肉・歯周疾患 その他
その他の疾病・異常	なし・あり	聴力	右		
			左		
就学に関し保健上必要な助言					
備考					

※学校医、学校歯科医の署名（もしくは押印）は、札幌市学校医等執務記録簿への署名（もしくは押印）を以て充てる。

札幌市教育委員会