Tokyo West International School

Health Questionnaire健康調査票 (1/2)

Filled out by ***Parent/Guardian*** (保護者の方ご記入ください)

Student Name 生徒名前			
Surname姓	First Name 名		Middle Name
Sex 性別	Male □ Female □	Date of Birth 生年月日	YYYY / MM / DD

<Food>

Favorite food 好きな食べ物:	Least favorite food 苦手な食べ物:
Food Allergy 食品アレルギーの有無: Yes □ No □ If yes, please describe:	

<Health>

Pediatric hospital name 係りつけの病院:	
Pediatrician 担当医:	
Address 住所:	
Telephone number 電話番号:	
Past illness 既往症:	
Allergy アレルギーの有無: If yes, please describe:	Yes □ No □

<Immunization/予防接種**>** Date Immunized 接種時期

Streptococcus pneumoniae (小児肺炎球菌)	1	YYYY / MM	Viral Hepatitis type B (B型肝炎)	1	YYYY / MM
	2	YYYY / MM		2	YYYY / MM
	3	YYYY / MM		3	YYYY / MM
	4	YYYY / MM			
Japanese Encephalitis (日本脳炎)	1	YYYY / MM			
	2	YYYY / MM			
	3	YYYY / MM	MR (麻疹風疹)	1	YYYY / MM
	4	YYYY / MM		2	YYYY / MM
DPT-IPV-Hib (5種混合)	1	YYYY / MM	Mumps (おたふく)	1	YYYY / MM
	2	YYYY / MM		2	YYYY / MM
	3	YYYY / MM	Rotavirus (ロタウィルス)	1	YYYY / MM
	4	YYYY / MM		2	YYYY / MM
Varicella (水痘)	1	YYYY / MM	BCG	1	YYYY / MM
	2	YYYY / MM	Others その他		YYYY / MM
					YYYY / MM

Tokyo West International School

Health Questionnaire健康調査票 (2/2)

<Medical History/Condition of Your Child>

Eye Condition/Wearing Glasses 眼鏡等使用・目の病気	Difficult seeing 弱視/視力低下	Yes □ No □	Glaucoma 緑内障	Yes □ No □	Others その他	
	Wearing glasses 眼鏡等使用	Yes □ No □	Squint 斜視	Yes □ No □		
Respiratory Condition 肺・呼吸関係の病気 (ぜんそくなど)	Asthma ぜんそく	Yes □ No □	Pneumothorax 気胸	Yes □ No □	Others その他	
	Hyperventilation 過換気症候群	Yes □ No □	Breathlessness 呼吸困難	Yes □ No □		
Skin/dermatological condition 皮膚の異常(アトピーなど)	Atopic Dermatitis アトピー性皮膚炎	Yes □ No □	Eczema 湿疹	Yes □ No □	Lice シラミ	Yes □ No □
	Urticaria じん麻疹	Yes □ No □	Psoriasis 乾癬	Yes □ No □	Photosensitivity 日光過敏症	Yes □ No □
	Other その他					
Bone/muscles/joint condition **筋肉/骨格/関節の異常**	Braces 義肢・義足	Yes □ No □	Arthritis 関節炎	Yes □ No □	Scoliosis 背骨のわん曲	Yes □ No □
	Fracture 骨折	Yes □ No □	Disk Hernia 椎間板ヘルニア	Yes □ No □	Deformity 変形	Yes □ No □
	Gait 歩行	Normal □ Abnormal □	Congenital Condition 先天性疾患	Yes □ No □	Others その他	
	*Diagnosis of Congenital Condition 診断名					
Psychological/learning condition 心理/精神状態	Psychological consult 心理療法の経験	Yes □ No □	Learning Difficulty 学習障害	Yes □ No □	Inappropriate Maturation 年齢と精神発育の一致	Yes □ No □
	Behavioral Problem 行動障害・異常	Yes □ No □	Delay in Mental Growth 精神発達遅延	Yes □ No □	Attention Deficit 注意/集中力欠如	Yes □ No □
	Congenital Condition **先天性疾患**	Yes □ No □	*Diagnosis of Congenital Condition 診断名		Others その他	
Neuron 神経	Patellar reflexes 膝蓋腱反射	Normal □ Abnormal □	Other その他			

<Authorization>

I, _____(Parent's name) declare that the information supplied is true to the best of my knowledge. If I cannot be reached to give my consent to the first aid/emergency procedures, or if the school health services find necessity of quick first-aid, I hereby give my permission to Tokyo West International School to seek medical treatment or in-school first aid by the school employee for my child in case of injury or illness which is incurred while participating in school-sponsored activities.

Parent's/Guardian's Signature:_____

Date:_____