

Survey slip for the start-of-elementary-school health checkup

Hiragana	
Name of child	

Start-of-elementary-school health checkup notification number	
No.	(Write the "Start-of-elementary-school health checkup notification" number that is provided at the bottom of the Start-of-elementary-school notification.)

* Check your child's health on the day of the start-of-elementary-school health checkup before coming to the school. Do not let your child get the start-of-elementary-school health checkup if they have a fever (37.5°C or higher).

1. Circle the diseases that your child currently has, and write the details in the () of any diseases that your child has had in the past.

Disease	Currently has	Has had in the past	Disease	Currently has	Has had in the past
Heart disease		(Age:) (until age)	Diabetes		(Age:) (until age)
Heart disease Childhood tuberculosis		(Age:) (until age)	Kidney disease		(Age:) (until age)
Asthma		(Age:) (until age)	Convulsions Cramps		(Age:) (until age)
Food allergies (food name(s))		(Age:) (until age)	Measles		(Age:) (until age)
Allergies		(Age:) (until age)	Other		(Age:) (until age)

2 Circle the immunization shots that your child has received. If your child has never been immunized, circle [None].

• BCG [None / Finished]	• Has received MR (measles and rubella) shots [1st / 2nd]
• Has received DPT-IPV (whooping cough, diphtheria, tetanus, polio) shots [1st / 2nd / 3rd / 4th]	• Has not received MR shots
• Has not received DPT-IPV shots	• Measles (single) [None / 1st / 2nd]
• Polio (single) [None / Finished]	• Rubella (single) [None / 1st / 2nd]
• DPT (whooping cough, diphtheria, tetanus) [None / 1st / 2nd / 3rd / 4th]	• Japanese encephalitis [None / 1st / 2nd / 3rd]
• Chickenpox [None / 1st / 2nd]	• Hib infections [None / 1st / 2nd / 3rd / 4th]
• Hepatitis B [None / 1st / 2nd / 3rd]	• Pediatric pneumococcal vaccine [None / 1st / 2nd / 3rd / 4th]

3 Concerns regarding your child's listening and speaking.

Do you have any concerns regarding your child's listening and speaking?
Please put a check in either ☐ No or ☐ Yes.

☐ No

☐ Yes

If Yes, check any items that apply regarding listening or speaking.

- ☐ My child seems to have difficulty hearing.
- ☐ You often have to repeat yourself.
- ☐ Your child turns the TV volume high.
- ☐ My child speaks slowly.
- ☐ My child's pronunciation is unclear.

Please check any items that apply to consultations or visits to a medical institution for listening or speaking symptoms.

Has your child with listening or speaking symptoms had a consultation or visit at a medical institution for their symptoms?

* For children who have not had consultations or visited a medical institution but would like to receive a hearing test, check

☐ Has had consultation or visit

☐ Was seen by the otorhinolaryngology department

☐ Visited a regional rehabilitation center or similar medical institution.

☐ No consultation or visit

☐ I do request a hearing test during the health checkup

☐ I do not request a hearing test during the health checkup

4. Write any concerns you may have about your child's health.

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