〈 Sample 〉

◆This questionnaire is only used for emergency, and will not be used for other purposes.

20○○ HOUSEHOLD QUESTIONNAIRE

○○ Elementary School grade class

① Children

Hiragana		Male Female	Birthday / /
Name			
Present address			town

② Parent

Hiragana		Relationship
Name		
Present address	※Please fill in if the parent's address is different from the student's.	

③ Family members (including the student)

	Relationship	Name	Age	Name of Employment / School / Grade and Class
1				
2				
3				
4				
5				
6				
7				
8				

④ Contact address

Landline phone number		
※Write two or more numbers of your cell phones, Including the one of the parent's work place.		
for Emergency Priority	Name (ex. father's name, or name of mother's work place)	Phone number
1		
2		
3		

⑤ Activity outside school

※Please fill in if have any private school, juku, or club activity	Private school or Club activity	Day	Time	Place

⑥Special Requests or Help

※about study, school life, health etc.

⑦Map

※You must draw Map A. It will be used when the teacher visits your home. Please draw Map B if necessary. Both Map A and B would be helpful.

○Draw a map including some landmarks, shops or signs, and trace your child's route to school in red line.

○Point out some park places near your home if possible.

○If your home is far from the school, you can omit the map partially.

Map A: From your home to the school

Map B: If your child should go somewhere other than your house, please draw Map B

※exclude the after school care

Name of the head of household Relationship（ ）	Address	Phone number

〈 Sample 〉

CONFIDENTIAL　　HEALTH QUESTIONNAIRE

This questionnaire will be important information for the school to know about your child's health condition and to do the health care for your child. We will use this questionnaire for 6 years, so please keep it safe.
Please add necessary information every April.

Hiragana / Name		Year	H	H	H	H	H	H
Birthday	/　/	Grade	1	2	3	4	5	6
Parent's name		Class						
Present address	TEL							
	TEL	Your family doctor						
	TEL	Surgery						
Contact address for emergency (must fill in)		Internal medicine						
Name / Relationship( )	Contact address TEL	Other						
Name / Relationship( )	Contact address TEL	Other						
Name / Relationship( )	Contact address TEL	Type of your insurance policy						
		・National Insurance ・Social Insurance ・Seamen's Insurance ・Other ( )						

1)Please circle your child's allergies.

・Asthma　(House dust ・ Pollen ・ Other _____)
・Food allergy　(Eggs ・ Milk ・ other _____)
・Allergy to medicine for external use(　　)
・Allergy to oral medicine (　　)
・Sick school syndrome・Chemical sensitivity (　　)

2)Please circle the diseases your child had previously, or against which he/she has been vaccinated. Please write the age when he/she had it in the parenthesis.

・Heart disease (　) ・TB (　) ・Rheumatic fever (　)
・Liver trouble (　)
・Kidney disease (　) ・Kawasaki disease (　)
・Convulsions (　) (・taking medical examination ・taking medicine)
・Operation (　) ・Measles (　) ・Rubella (　)
・Chicken Pox (　) ・Mumps (　) ・other (　) (　)

3)About the healthy conditions and symptoms of your child, please check the appropriate box.

	Symptom \ Grade	1	2	3	4	5	6	Medical Things to be Taken Care of (appendicular moves, color blindness, hearing disablitiy, etc)
Internal medicine	frequent stomachaches							1st grade
	frequent headaches							
	difficulty in waking up							
	frequent cerebral anemia							2nd grade
	palpitation, breathlessness							
	chest pain after sport							
	atopic dermatitis							3rd grade
	asthma							
ENT	frequent bloody nose							4th grade
	frequent stuffy nose							
	hearing disability							
	treating middle ear infection now							
	allergic rhinitis							5th grade
Ophthalmic	frequent eye mucus							
	difficulty in seeing the letters on the blackboard							6th grade
	farsighted eyes needed to take regular medical examination							