Child Status Report
児　童　状　況　届

(Please fill out the necessary information and check the applicable boxes)

Name of the Applicant Child	Date of Birth: (YYYY/MM/DD) [/ /]

① Childcare Situation

Current Childcare Situation	Provided by Parent/Guardian	☐ At home	Who?	☐ Father ☐ Mother	Maternity/Childcare Leave End Date	/ /
		☐ At work	Details	☐ Using daycare facility at work ☐ Providing care while working (e.g. at own business)		
		☐ Other	Details			
	Provided by Someone Else	☐ A relative	Relation			
		☐ Someone other than a relative	Relation			
		☐ Certified childcare facility in the city	Facility Name		Start Date	/ /
		If using on-site childcare services at a business	☐ Regional quota	☐ Employee quota		
		☐ Certified facility outside of the city	Facility Name		Start Date	/ /
		☐ Non-certified childcare facility	Facility Name		Start Date	/ /
		☐ Temporary childcare services	Facility Name		Start Date	/ /
		☐ Kindergarten	Facility Name		Start Date	/ /
		☐ Other ( )				
Any past experiences with group childcare? (Other than above)		☐ No ☐ Yes (If "Yes", please fill out the following section)				
		Facility Name		Usage Period	/ / to / /	
Have you used an educational therapy facility?		☐ No ☐ Yes (If "Yes", please fill out the following section)				
		Facility Name		Usage Period	/ / to / /	

② Other Children Under School Age

*Do not fill this out if your child does not have any siblings under school age.

If you are applying for your other children **at the same time**	If would like to enroll all children in the same month	☐ I would like to enroll all children in the same month	(*All children will wait even if only one child cannot be enrolled.)
		Facility Assignment	☐ All children must be enrolled at the same facility
			☐ I will accept enrollment at different facilities if necessary
	If you will accept enrollment in different months	☐ I would like to enroll my children in order of acceptance if it is not possible to enroll all children in the same month (even if one is enrolled before the others)	
If you are not applying for the other children, please explain why	☐ Already using a facility (certified, non-certified, temporary, etc.) ☐ Relative providing childcare ☐ Using workplace daycare ☐ Providing care while working (e.g. at self-owned business) ☐ Other (Details:)		

③ Future Childbirth Plans

Are you expecting?	☐ No ☐ Yes (Expected delivery date: ___/___/___, ☐ I am expecting twins, triplets, etc.)

④ Status of Grandparents Living in a Separate Residence

*You must indicate grandparents living on the same premises in the "Household Status" section of the application form.

	Name	Relation	Age	Address	Transportation/Time to Applicant Child's Home (Only if living in the city)		Workplace & Work Hours		Health Condition
Paternal		Grandfather			Transportation		Workplace		☐ Normal ☐ Poor ☐ Other ( )
					Travel Time	mins.	Work Hours	hrs/month	
		Grandmother			Transportation		Workplace		☐ Normal ☐ Poor ☐ Other ( )
					Travel Time	mins.	Work Hours	hrs/month	
Maternal		Grandfather			Transportation		Workplace		☐ Normal ☐ Poor ☐ Other ( )
					Travel Time	mins.	Work Hours	hrs/month	
		Grandmother			Transportation		Workplace		☐ Normal ☐ Poor ☐ Other ( )
					Travel Time	mins.	Work Hours	hrs/month	

⑤ Other Information Related to Childcare Facility Use

How will transportation be provided for the child?	Main Provider	Drop-off		Method	☐ Car ☐ Bicycle ☐ Walking ☐ Public transp.	Travel Time	mins.
		Pick-up		Any transportation restrictions?	(e.g. do not own a car, etc.)		
Alternative childcare plans if on standby	☐ Extend childcare leave (until ___/___/___) ☐ Workplace daycare ☐ Non-certified facility ☐ Granparents will provide care ☐ Other (Details:)						
Other Important Notes							

※ Please fill out the other side

⑥ Health Condition of the Child

Health Condition of the Child

Weight (Birth-Present)	Weight at Birth	g　Pregnancy Duration　weeks　Current Weight　g・kg
Developmental Conditions	Head Control　months　Sitting　months　Crawling　months　Teething　months　Walking　months	
	Current Walking Status	☐ Crawling on belly ☐ Crawling on hands and knees ☐ Standing w/ support ☐ Walking w/ support
	Does the child make noises as if trying to speak when w/ family?	☐ Yes ☐ No　First Word　months
	Current Speech Level	☐ Single words ☐ Two-word sentences ☐ Can have conversations
	Has your child had their 18-month checkup? (*Only answer if 18 months or older)	☐ Yes ☐ No
	If you answered "Yes"	Provide details of any advice or notes given by the doctor/nurse during the checkup.
	If you answered "No"	Please explain why your child has not received the checkup.
	Has your child had their 3-year checkup? (*Only answer if 3 years or older)	☐ Yes ☐ No
	If you answered "Yes"	Provide details of any advice or notes given by the doctor/nurse during the checkup.
	If you answered "No"	Please explain why your child has not received the checkup.
Vision	Do you have any concerns about your child's vision?	☐ No ☐ Yes [※ If "Yes", please check the applicable boxes below.] ☐ Squints or has to be very close to things in order to see them ☐ Glances upwards or looks out the corner of the eyes to see things ☐ Needs glasses (☐ Farsightedness ☐ Lazy eye ☐ Other [ ]) ☐ Other [ ]
Hearing	Do you have any concerns about your child's hearing?	☐ No ☐ Yes [※ If "Yes", please check the applicable boxes below.] ☐ Doesn't turn around when called from behind ☐ Appears to have a speech delay ☐ I have noticed something about their speech or understanding ☐ Other [ ]
Convulsions	Has your child experienced convulsions?	☐ No ☐ Yes [※ If "Yes", please fill out the following section.] # of times　Date of Most Recent　/ (YYYY/MM)　Temp. during convulsions　℃ Describe their condition during convulsions
Allergies	Food allergies? Taking any medication?	**This section must be completed if your application indicates your child has allergies.** What food(s) are they allergic to? Has the child experienced anaphylaxis? ☐ No ☐ Yes Does the child take any medication? ☐ No ☐ Yes　If "Yes", which medication? EPIPEN ・ Internal medicine　Medicine Type [ ]
Outpatient & Hospitalization History	Does your child have a history of outpatient care or hospitalization?	☐ No ☐ Yes [※ If "Yes", please fill out the following section.] Age while outpatient/hospitalized　years　months　Diagnosis Age during surgery (if applicable)　years　months　Type of Surgery Hospital Name Current Condition ☐ Completely recovered ☐ Receiving follow-up care ☐ Receiving outpatient care (# of days per week ・month: [___], Hospital: [_____]
Currently Treated Illness	Is your child currently being treated for an illness?	☐ No ☐ Yes [※ If "Yes", please fill out the following section.] Diagnosis Does your child take any medication? ☐ No ☐ Yes　If "Yes", which medication? Type of Medicine [ ]
	Is there anything else about your child's developmental/ health condition that needs attention during group childcare or that you would like the childcare facility to know?	☐ No ☐ Yes [※ If "Yes", please fill out the following section.]

The following is for city office use only.

記 録 内 容	応答者	父 ・ 母 ・ 祖父 ・ 祖母 （父方・母方） ・ その他（ ）		
	面接員		面接日	令和　年　月　日