

《Status Report》For guardian

Filled by: Father・Mother・Other () Date YY MM DD

Name of child			M · F	Date of birth	YY	MM	DD (Age)
Disability type and level	<input type="checkbox"/> Physical disability certificate (Type Grade) <input type="checkbox"/> Ai-no-techo (Degree) <input type="checkbox"/> Mental health certificate (Grade) <input type="checkbox"/> No certificate/techo						
Nursery School Kindergarten	Nursery school Kindergarten					<input type="checkbox"/> Not attending	
School	Elementary · Junior high · Senior high school				Regular class · Support class · Fixed class · Special needs school		
Hospital visit	Name	Hospital/clinic Dept.			Frequency	days/Mo. · Irregular visit	
	Name	Hospital/clinic Dept.			Frequency	days/Mo. · Irregular visit	
Family Status ※Not Include him/herself ※Write in the remarks field if you need more space.	Guardian	Name	Relation	Age	Work · School		Health
					<input type="checkbox"/> Work <input type="checkbox"/> Unemployed (<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time)	Nearest station 【 : ~ : 】 Work hour 【 : ~ : 】	<input type="checkbox"/> Good <input type="checkbox"/> Has illness
					<input type="checkbox"/> Work <input type="checkbox"/> Unemployed (<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time)	Nearest station 【 : ~ : 】 Work hour 【 : ~ : 】	<input type="checkbox"/> Good <input type="checkbox"/> Has illness
					<input type="checkbox"/> Attending <input type="checkbox"/> Not attending	Name of school	<input type="checkbox"/> Good <input type="checkbox"/> Has illness
	Sibling				<input type="checkbox"/> Attending <input type="checkbox"/> Not attending	Name of school	<input type="checkbox"/> Good <input type="checkbox"/> Has illness
					<input type="checkbox"/> Attending <input type="checkbox"/> Not attending	Name of school	<input type="checkbox"/> Good <input type="checkbox"/> Has illness
					<input type="checkbox"/> Attending <input type="checkbox"/> Not attending	Name of school	<input type="checkbox"/> Good <input type="checkbox"/> Has illness
	Other				<input type="checkbox"/> Live together <input type="checkbox"/> Separated ()	Childcare Collaboration <input type="checkbox"/> Regularly <input type="checkbox"/> Occasionally <input type="checkbox"/> Difficult	<input type="checkbox"/> Good <input type="checkbox"/> Has illness
					<input type="checkbox"/> Live together <input type="checkbox"/> Separated ()	Childcare Collaboration <input type="checkbox"/> Regularly <input type="checkbox"/> Occasionally <input type="checkbox"/> Difficult	<input type="checkbox"/> Good <input type="checkbox"/> Has illness
					<input type="checkbox"/> Live together <input type="checkbox"/> Separated ()	Childcare Collaboration <input type="checkbox"/> Regularly <input type="checkbox"/> Occasionally <input type="checkbox"/> Difficult	<input type="checkbox"/> Good <input type="checkbox"/> Has illness
					<input type="checkbox"/> Live together <input type="checkbox"/> Separated ()	Childcare Collaboration <input type="checkbox"/> Regularly <input type="checkbox"/> Occasionally <input type="checkbox"/> Difficult	<input type="checkbox"/> Good <input type="checkbox"/> Has illness
	Developmental issues	<input type="checkbox"/> Speech delay <input type="checkbox"/> Interacting with people <input type="checkbox"/> Learning delay <input type="checkbox"/> Difficulty understanding explanations and directions <input type="checkbox"/> Eyesight <input type="checkbox"/> Hearing <input type="checkbox"/> Intractable disease (name of disease:) <input type="checkbox"/> Physical problem <input type="checkbox"/> Other ()					
Daytime activity (nursery, school, etc.)	(e.g.) Having fun with friends, lack of communication, after school activities, etc.						
At home / environment	《How to spend time at home, favorite games》 《Location and surroundings of the residence 》 (e.g.) Time to buspoint and nearest station, etc.						
Medical care	Yes · No						
	<input type="checkbox"/> Respirator <input type="checkbox"/> Suction <input type="checkbox"/> Hypodermic <input type="checkbox"/> Defecation control <input type="checkbox"/> Central venous <input type="checkbox"/> Nebulizer <input type="checkbox"/> Oxygen therapy <input type="checkbox"/> Tracheotomy <input type="checkbox"/> Nasopharyngeal airways <input type="checkbox"/> Tube feeding <input type="checkbox"/> Continuous dialysis <input type="checkbox"/> Urine drainage <input type="checkbox"/> Suppository use, suction, oxygen supply, or vagus nerve stimulator activation during cramps <input type="checkbox"/> Blood glucose control test						
Remarks							

※This is to help us understand the status of you and your family. Fill in as much as you know.