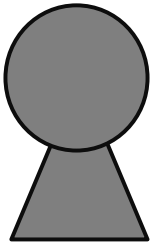


- Day Care
- Twilight
- Short Stay Accomodation

Questionnaire for Nursery

Pokke ID ()

Date of Application / /

Child's part			
Child's name	<input type="checkbox"/> M	Birthday: Y/M/D	
	<input type="checkbox"/> F	/ /	
Nickname:		Ages: ___ years ___ months	
The Grade of School :		<input type="checkbox"/> not going <input type="checkbox"/> kindergarten <input type="checkbox"/> nursery school <input type="checkbox"/> elementary school	
School name:		_____ school grade : _____	
Guardian's part			
Address 〒 _____			
Phone Tel :		Fax :	
Guardian's name		Relation-ship	
Family members: <input type="checkbox"/> father <input type="checkbox"/> mother <input type="checkbox"/> grand father <input type="checkbox"/> grand mother <input type="checkbox"/> brother(s) : (____) <input type="checkbox"/> sister(s) (____)			
if you are living separately from the child, Address:			

■ Questionnaire for medical condition

Condi- -tion	normal temperature (°C)	
	a chronic illness:	none having()
	allergic:	none having()
	convulsions for high fever:	none did (how many? _____ Time(s))
	previous illness:	<input type="checkbox"/> pneumonia <input type="checkbox"/> asthma <input type="checkbox"/> dislocation <input type="checkbox"/> convulsion <input type="checkbox"/> Kawasaki illness
	Other special mention: Ex.) enter the hospital or any operation()	
Vaccinated <input type="checkbox"/> BCG <input type="checkbox"/> DPT(Diphtheria·Pertussis·Tetanus) <input type="checkbox"/> Polio <input type="checkbox"/> MR(Measles·Rubella) <input type="checkbox"/> Varicella <input type="checkbox"/> Mumps <input type="checkbox"/> Influenza		
Family doctor:		<input type="checkbox"/> Health insurance certificate ⇒ No.
TEL:		<input type="checkbox"/> Child medical insurance certificate ⇒ No.
		<input type="checkbox"/> Mother & Child hand-book ⇒ No.

■ Questionnaire for meal

Meal	allergic:	Baby food	Milking
	dislike food:		milk(cc/time) interval _____hours
	quantity: lot · moderate · little		Baby foods
	support : need · needless		weaning food _____time/day
	enable to use: fork/spoon · chopsticks		<input type="checkbox"/> pasty <input type="checkbox"/> cut into fine piece <input type="checkbox"/> cut into the piece roughly

■ Questionnaire for toilet

Toilet	<input type="checkbox"/> diaper <input type="checkbox"/> Toilet training <input type="checkbox"/> shorts
	tend: <input type="checkbox"/> hard <input type="checkbox"/> moderate <input type="checkbox"/> soft

■ Questionnaire for sleeping

Sleep- -ing	an afternoon nap: <input type="checkbox"/> none <input type="checkbox"/> taking (from: _____ : _____ hours)	
	habit to sleep: <input type="checkbox"/> with someone beside him/her <input type="checkbox"/> able to sleep alone <input type="checkbox"/> on one's back <input type="checkbox"/> pickking up <input type="checkbox"/> Others:	
Favorite plays and toys		Home discipline/religious content
how to care (crying)		spcialized care:
Remark:		