Form 4

Medical Report Form

Date: (Y/M/D)

Name of Parent/Guardian:

Name of Child	Gender	Date of Birth	Age
	M・F	(Y/M/D)	year months old

1. Please place ○ to select the disease below that your child currently has.(check all that apply)

※In addition, Attending Physician's Report may be required to submit.

Asthma		Epilepsy	
Medicine hypersensitivity		Febrile convulsions	
Heart disease		Allergic diathesis	(specify:)
Developmental delay		Others	(specify:)

2. Abnormality during pregnancy or delivery: ☐ Yes (specify:)
☐ No

3. Delivery: ☐ On schedule
☐ ( )week(s) earlier than the estimated due date
☐ ( )week(s) later than the estimated due date

Weight at birth ( )g Length at birth ( )cm

4. Please mark the disease below that your child has ever had in the past.(check all that apply)

☐ Measles ☐ Varicella ☐ Mumps ☐ Whooping cough

☐ Rubella ☐ Atopic dermatitis ☐ Medicine allergy ☐ Convulsions

☐ Hospitalization (specify:

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