Japan Sport Council Accident Mutual Benefit Plan

〇〇〇Board of Education

Congratulations on your child’s entrance.

The 〇〇〇Board of Education has entered a mutual benefit plan with the Japan Sport Council (hereafter "the Council") in order to protect your child in the event of an accident while at 〇〇〇〇〇〇School.

The Council's Accident Mutual Benefit Plan provides financial support for medical expenses or grievances incurred in the event that your child is injured or involved in an accident while under the school's supervision. In accordance with the terms of agreement, a name list of enrolled students will be submitted to the Council. Enrollment is optional. For parents who wish to enroll, please fill out the consent form below and submit it to the school principal.

The process of entering the Accident Mutual Benefit Plan is conducted through an internet system. The system will maintain all personal information confidential and secure.

The terms and content of the benefit plan have been drafted according to the Japan Sport Council Law (hereafter "Council Law") and are based upon Japanese government and ministerial ordinances, and other circular notices. The terms of the agreement are subject to revision. The main terms as of January 1, 2012 are described below.

1. Compensation Types and Content

(Standards for benefits are based upon Article 3 of the "Council Law" Enforcement Ordinance)

<table>
<tr><th>Type of Accident</th><th colspan="2">Scope of Accident</th><th>Amount of Compensation</th></tr>
<tr><td>Injury</td><td colspan="2">If the injury occurs while under the school's supervision, and the cost of medical care exceeds 5,000 yen.</td><td rowspan="2">Medical Expenses
●40% of costs for medical treatment (equivalent to medical insurance), 10% of which will cover additional expenses that will be incurred along with medical treatment. However, if you are eligible for high cost medical care, 10% of the costs to be paid on your own will be additionally covered. (There is a limit in compensation according to your income.)
●If there is a standard rate for meals during hospitalized care, that amount will be additionally covered.</td></tr>
<tr><td>Illness</td><td colspan="2">If the illness occurs while under the school's supervision, the cost of medical care exceeds 5,000 yen, and the illness is stipulated in the ordinance of the Ministry of Education, Culture, Sports, Science and Technology.
・Food poisoning from school lunch ・Poisoning by gas ・Heatstroke ・Near drowning ・Illness due to swallowing a foreign object ・Inflammation of skin due to lacquers, etc.
・Illness due to exterior sanitation ・Illness due to injury</td></tr>
<tr><td>Disability</td><td colspan="2">Disabilities resulting from an injury or illness which occurs while under the school's supervision.</td><td>Disability Grievance Compensation
37,700,000 yen to 820,000 yen
(half for accidents during commute)</td></tr>
<tr><td rowspan="3">Death</td><td colspan="2">Death resulting from an accident caused while under the school's supervision, or death resulting directly from an illness caused by the school.</td><td>Grievance Compensation for Death
28,000,000 yen
(14,000,000 yen for accidents during commute)</td></tr>
<tr><td rowspan="2">Sudden Death</td><td>Sudden death caused by physical activity.</td><td>Grievance Compensation for Death
28,000,000 yen (half for accidents during commute)</td></tr>
<tr><td>Sudden death unrelated to physical activity.</td><td>Grievance Compensation for Death
14,000,000 yen (same for accidents during commute)</td></tr>
</table>

(*Grievance Compensation covers expenses that were incurred after 2005)

The following specifies the circumstances described by the term, "under the school's supervision"

① During class hours (or during supervision at a daycare, etc.)
② Extracurricular instruction in accordance with the school's educational program
③ Recess and other designated school times
④ Commute to school/facility according to usual route and method.
⑤ While at a boarding lodge, dormitory, etc.

2. Compensation Standards

① Compensation for the medical treatment of injuries and illnesses resulting from a single accident shall be provided for a maximum period of ten years from the first medical consultation.
② If you do not make any claims for two years after the occurrence of the illness/injury, you will lose your right to claim compensation.
③ If you receive benefits or compensation from other sources (such as a Local Public Entity Child Medical Care Assistance Plan, or a Single Parent Family Medical Care Assistance Plan), this benefit plan will not cover the expenses covered by the other sources.
④ Children from households receiving financial support from the Daily Life Protection Law who suffer an accident while attending a daycare or the like, or a school for compulsory education, are not eligible for medical cost compensation from this plan.
⑤ If a high school student or student at a specialized high school voluntarily commits a crime and/or voluntarily causes a self-injury resulting in illness or death, this plan will not provide compensation for any medical costs, or any disability or death related expenses.
⑥ If a high school student or student at a specialized high school voluntarily commits a grave error that results in injury, illness, or death, there is a possibility that this plan will not cover the accident benefits regarding related disabilities or death.

* The above outlines the Japan Sport Council Accident Mutual Benefit Plan.

3. Compensation Premium (Annual Fees)

Parent Guardian Contribution:________________yen
(○○○Board of Education Contribution:________________yen)

-- CUT HERE --

Consent Form

To ○○○ Board of Education,

School Name: ___________________ (Department: ___________________)
Grade: ___________________ Name: ________________________

By enrolling my child in the Accident Mutual Benefit Plan drafted by the Japan Sport Council in conjunction with the Board of Education, I agree to the above terms and stipulations.

Date: ___________________

Name of Parent/ Guardian: ____ Seal______

[Confidential] Health Questionnaire

Elementary School			ES Gr. 1: Class No.	ES Gr. 4: Class No.	JH Gr.1: Class No.
Junior High School			ES Gr. 2: Class No.	ES Gr. 5:Class No.	JH Gr. 2: Class No.
Name Date of Birth: Year /Month /Date			ES Gr. 3: Class No.	ES Gr.6: Class No.	JH Gr. 3: Class No.
			Name of Parent/Guardian		
Address TEL					

○ **Emergency Contact Number** **Tick ☑ the contact convenient for you.*
If you would like to change your contact information, please contact us.

① Contact to [☐Office (Name:)/☐Home/☐Mobile] of the person below. (Relation) Name TEL: Mobile Phone:
② Contact to [☐Office (Name:)/☐Home/☐Mobile] of the person below. (Relation) Name TEL: Mobile Phone:
<Revision> Contact to [☐Office (Name:)/☐Home/☐Mobile] of the person below. (Relation) Name TEL: Mobile Phone:

○ **Family Clinics**

Physician/Pediatrician	Surgeon/Orthopedist	Dentist
Tel	Tel	Tel

○ **Present Conditions and Medical History (If applicable, draw a circle ○ in the box and if not, check ✓ the box.)**

	Condition	ES 1	ES 2	ES 3	ES 4	ES 5	ES 6	JH 1	JH 2	JH 3
1	Feeling ill recently.									
2	Having frequent diarrhea.									
3	Having frequent constipation.									
4	Having frequent stomach/abdominal pain.									
5	Sometimes having joint pain.									
6	Having frequent headaches.									
7	Taking anticonvulsant drugs.									
8	Having atopic dermatitis.									
9	Having allergic rhinitis.									
10	Having allergic conjunctivitis.									
11	Can't wake up in the morning unless woken up.									
12	Waking up feeling unwell and difficult to get up in the morning.									
13	Being very picky about food.									
14	Seldom having breakfast.									
15	Having frequent feelings of motion sickness.									
Girls	Having menstrual pain. First menstruation:(ES/JH Gr.: Month:)									

○ **Please write any food allergies or side effects from drugs that your child has experienced, if applicable.**

Name of Food	Age	Symptoms	Name of Drug	Age	Symptoms

Name

○ **If your child has suffered/is suffering from any of the diseases below, please write down the details.**

Disease Name	Age	Disease Name	Age	Disease Name	Age	Disease Name	Age
Measles		Rubella		Chicken Pox		Mumps	

Disease Name	Age	Cured	Under treatment	
Renal Disease		☐	☐	Other disease that required surgery/hospitalization Disease Name ( ) Period of Surgery/Hospitalization Year /Month to Year /Month
Heart Disease		☐	☐	
Kawasaki Disease		☐	☐	
Asthma		☐	☐	Other disease that required surgery/hospitalization Disease Name ( ) Period of Surgery/Hospitalization Year /Month to Year /Month
Febrile Convulsion		☐	☐	
Otitis Media		☐	☐	
		☐	☐	

○ **Vaccination Record (Please be sure to fill in the correct information, referring to your Mother-Child Handbook, etc.)**

Vaccination Name		Vaccination Date	Vaccination Name		Vaccination Date
BCG		Y /M /D	Polio	1st dose	Y /M /D
Diphtheria, Pertussis and Tetanus (DPT)	1st dose 1st period	Y /M /D		2nd dose	Y /M /D
	2nd dose 1st period	Y /M /D		3rd dose (of killed vaccine)	Y /M /D
	3rd dose 1st period	Y /M /D		Additional Dose (of killed vaccine)	Y /M /D
	Additional dose 1st period	Y /M /D	Japanese encephalitis	1st dose 1st period	Y /M /D
Measles-Rubella (MR) 1st period		Y /M /D		2nd dose 1st period	Y /M /D
Measles-Rubella (MR) 2nd period		Y /M /D		Additional dose 1st period	Y /M /D

○ **Communication between Home and School (Please write down detailed conditions on diseases/injuries under treatment, if any. If none, draw a circle ○ in the "None" box)**

Grade	Normal Temp.	None	Message
Example	36.5℃	(○ if none)	He visits **** Hospital twice a month for asthma and takes drugs every day. He has no exercise limitation other than when attacks occur. He has food allergies to ****. He reacts to even a little bit of **** juice, so please don't let him drink any. He is often irritated and feels uneasy. An Accident Continuation Report has been submitted for his bone fracture.
ES 1			
ES 2			
ES 3			
ES 4			
ES 5			
ES 6			
JH 1			
JH 2			
JH 3			

Date: Y /M /D

Dear Parents/Guardians,

Principal

Medical Checkup Notice

The school will administer a medical checkup that has been designed to both promote the health of all students and to provide them with a happier, healthier educational experience. Your cooperation is greatly appreciated.

1. Types of Examination and Date (A check appears in all relevant boxes.)

No.	Checkup	Date				Grade
		Month	Day	Day of Week	Time	
☐1	Internal Checkup					
☐2	Body Measurement					
☐3	Dental Checkup					
☐4	Eye Checkup					
☐5	Ear, Nose & Throat					
☐6	Hearing Checkup					
☐7	Eyesight Checkup					
☐8	Urine Test					
☐9	Electrocardiogram					

2. Preparation for the Checkups

〇For the Internal Checkup and Body Measurement
*On the day before, be sure that your child takes a bath and his nails are clipped.
*Make sure your child is wearing clothes that he can take off and put on by himself.
*Write your child's name on his clothes and underwear.

〇For Dental Checkup
*After breakfast, make sure your child brushes his/her teeth.

〇For Ear, Nose and Throat Checkup
*Please ensure that your child’s ears are cleaned beforehand.

3. Other
The results of the checkups will be reported later.

Date: Y /M /D

Dear Parents/Guardians,

Principal

Results of Internal Checkup

Grade: Class: Name:

The following conditions were detected during the recent internal medical examination. Please consult with a specialist of the relevant field(s) and send your child to the doctor for a thorough examination as soon as possible.

[Observations & Diagnosis] *A check appears in all the relevant boxes.

1. Nutritional Condition:
   ☐Obesity Tendency ☐Poor nutrition ☐Possible anemic
2. Spine/Thorax/Limbs: ☐Possible abnormality
   ( )
3. Skin Trouble ☐Atopic dermatitis ☐Eczema ☐Other
4. Heart Trouble ☐ Irregular pulse ☐Irregular heartbeat
   ( )
5. Other

* Please submit the form below to the school after consulting a doctor. (The form must be completed by the doctor.)

Doctor's Medical Examination Report

Grade: Class: Name:

Examination report and advice to the school.

Diagnosis (Name of Ailment):

Treatment:

Advice to the school:

I hereby certify that the above information is accurate.

Date: Year / Month /Day

Name of the Hospital

Name of the Doctor Seal

Dental Health Questionnaire

Grade:	Class:	Name:

The condition of your teeth, gums, teeth alignment, dental bite, jaw joint, dental plaque, etc. will be assessed.
Please tick (☑) “Yes” or “No” for each of the following questions.
If you would like to consult with the School Dentist, please write the details in the box below.

Questions to check the condition of your teeth, gums and jaw

1. Do your jaw joints make sounds when you open or close your mouth? ....☐Yes/☐No
2. Do you have difficulty or feel pain when opening your mouth? ....☐Yes/☐No
3. Do you have teeth alignment worries? ....☐Yes/☐No
4. Do you have gum bleeding? ....☐Yes/☐No
5. Do you have toothaches or tooth sensitivity? ....☐Yes/☐No
6. Do you have difficulty in swallowing food? ....☐Yes/☐No
7. Do you worry about bad breath? ....☐Yes/☐No
8. Do you know what a CO is? ....☐Yes/☐No
9. Do you know what a GO is? ....☐Yes/☐No

Please write the matters that you would like to consult the School Dentist with here.

Year /Month /Date

Dear Parent/Guardian

School:______________________________

Principal:____________________________

Results of Dental/Oral Checkup and Family Dentist Visit Advice

Grade: Class: Name:

Please refer to each comment in the box headed with a circle (〇), which explains the results of the dental/oral checkup conducted on Month /Date .

Not Abnormal		No irregularities were detected at the checkup. Continue to brush carefully with fluoride tooth paste and floss and have a regular lifestyle with a balanced diet in order to maintain the present dental and oral condition. Consult your home dentist on a regular basis for your healthy mouth.

If you have one or more circles (〇) in the "Follow-up Needed" boxes: Please follow up with the condition at home while ensuring to brush the teeth carefully with fluoride tooth paste and floss and have a regular lifestyle and balanced diet. It is also recommended to consult your home dentist on a continual basis for advice and oral health management.

Follow -up Needed		CO	There are one or more nearly decaying teeth. They are likely to be decayed in the future. (☐ Baby Tooth ・ ☐ Adult Tooth)
		GO	Mild swelling and bleeding of gums have been observed. Gingivitis may occur in the future.
		Plaque Accumulation	Plaque has accumulated due to insufficient brushing.
		Arch, Bite, and Jaw Joints	There are slight concerns. See how condition develops.

If you have one or more circles (〇) in any of the boxes below: It is advised to be examined and treated soon. Return this form to the school after the consultation/treatment is over and the doctor has filled in the consultation/treatment results.

	Disease/Abnormality		Details	Results
Dentist Visit is Advised		C O & Need to Consult (C O-S)	There is a high probability of tooth decay. (☐ Baby Tooth ・ ☐ Adult Tooth)	☐Treatment completed ☐Continual follow-up
		Cavity (C)	There are one or more cavities (holding tooth decay). (☐ Baby Tooth ・ ☐ Adult Tooth)	☐Treatment completed ☐Continual follow-up
		Gingivitis (G)	Tartar is deposited on the teeth, causing gingivitis.	☐Treatment completed ☐Continual follow-up
		Tartar Deposition	Although there is no gingivitis, tartar is deposited on the teeth.	☐Treatment completed
		Irregular Arch/Bite	Remarkable irregularities in teeth alignment/bite are observed.	☐Treatment Started ☐Continual follow-up
		Abnormal Jaw Joint	Irregularities are found in the jaw joints.	☐Treatment completed ☐Continual follow-up
		Problematic Baby Tooth	One or more baby teeth remain where adult teeth should grow.	☐Treatment completed ☐Continual follow-up
		Plaque Accumulation	Large amount of plaque is accumulated on the teeth surface or new back teeth.	☐Treatment completed ☐Continual follow-up
		Others		☐Treatment completed ☐Continual follow-up

To the Home Dentist: Year /Month /Date

Please complete treatment after detailed examination, and then record the results of the consultation and treatment.

Name of the Medical Institution:

Name of the Dentist: (seal)

To Parent/Guardian

Of the above items listed as "Dentist Visit is Advised", teeth-straightening treatment for "Irregular Arch/Bite" is not covered by the National Health Insurance. If "Irregular Arch/Bite" is headed with a circle (〇) and you are not going to receive consultation or treatment, please sign your name and return this form to the school. Year /Month /Date

The student is not going to receive consultation or treatment of "Irregular Arch/Bite".

Name of Parent/Guardian: (seal)

[Front]

Eye Checkup Questionnaire

This Eye Checkup Questionnaire will be used to assess whether your child needs to undergo an eye checkup at school. Please answer the questions below frankly.

Grade:　　Class:　　NO.:　　Name:

Tick ☑ all applicable

	Question	✓
1	Having frequent eye discharge.	
2	Having frequent itchy eyes.	
3	Having frequent red eyes.	
4	Having frequent eye pain	
5	Having difficulty in seeing the blackboard.	
6	Using eye glasses.	
7	Using contact lenses.	
8	Having difficulty in distinguishing between certain colors (ex. green, red, etc.)	
9	Visited eye doctor over the past year.	
	If applicable, with what symptoms? ( )	
10	Would like to consult with an eye doctor.	
	If applicable, for what matters/symptoms? ( )	
11	Please write other concerns, if any ( )	

Please fill in the backside as well.

13	None of the above 1 to 10 is applicable, and having answered question 12 on the backside.	

* The boxes below will be filled in by the school, so leave them blank.

Result of Eye Checkup	Naked Eyes/With Glasses/With Contact Lenses (Circle the applicable one)	
	Eye sight under the above condition	Right (A B C D)
		Left (A B C D)

Result: No abnormalities / Follow-up required / Hospital visit required ( ) Others ( )

[Back]

Color Blindness Test

Congenital color blindness is found in about 5% of boys (one in 20 boys) and in about 0.2 % of girls (one in 500 girls).

People with color blindness experience almost no inconvenience in their daily lives. They may however, find it difficult to understand some lessons that use color materials/presentations, and will need proper attention at school.

Many of such students or their parents/guardians are not aware of their color vision deficiencies. It is important to receive a color blindness test so that students have an understanding of their color vision when they choose lessons to take and/or vocations and careers.

Upon reading and understanding the above, please answer whether you will receive the test or not.

	As for a Color Blindness Test:	✓
12	I would like to have one.	
	I am not going to have any.	

Parent/Guardian ______________________ Seal: ___

Y　　/M　　/D

Dear Parents/Guardians,

School Name:
Principal's Name:

Results of Eye Checkup

Grade:　Class:　　Name:

On the recent checkup, if a circle (○) appears to the left of any of the diseases listed below, your child is suspected of having that disease and please follow the advice that has been ticked off (☑) below the list. Please notify your child's attending teacher when the treatment is completed.

	Disease Name		Disease Name
	Chronic conjunctivitis		Chalazion
	Allergic Conjunctivitis		Hordeolum
	Follicular conjunctivitis		Vernal conjunctivitis
	Blepharitis		Cataract
	Entropion		

☐ 1 See an eye doctor as soon as possible.
☐ 2 See an eye doctor when symptoms appear.

Results of Checkup/Advice from the Doctor

Diagnosis (Disease name, etc.)		
Advice from the Doctor		
Swimming in a pool (Circle the applicable.)	Permitted	Forbidden

Year　　/Month　　/Day

Name of the Medical Institution:

Eye Doctor's Name:

Date: Y /M /D

Dear Parents/Guardians,

Principal

Results of Eyesight Checkup

Grade: Class: Name:

The results of the recent eyesight checkup are reported below. If either "B, C or D" is circled, please take your child to the doctor for a thorough examination.

Result

A	Above 1.0	B	…0.9~0.7	C	…0.6~0.3	D	Below 0.3

Eyesight	R( ) L( )	Eye. w/glasses	R( ) L( )

Please notify your teacher once your child has been examined by the doctor.

Eye Examination Results

	Right	Left
Eyesight	( )	( )
Eyesight w/glasses	( )	( )
Observations	Normal, Farsighted, Astigmatic weak-sighted, Nearsighted, Accommodative Spasm Other ( )	Normal, Farsighted, Astigmatic weak-Sighted, Nearsighted, Accommodative Spasm Other ( )
Treat. & Observ.	(Yes ・ No) [After Months]	
Instructions	Eye drops (Yes ・ No) Glasses (Yes ・ No ・ Renew ・ Observation) Wearing glasses (always ・ during classes only) Others ( )	

I hereby certify that the above information is accurate.

Date: Year / Month /Day

Name of the Hospital

Name of the Doctor Seal

Ear/Nose/Throat Health Questionnaire (For Elementary School Students)

Grade:　 Class:　 NO.:　 Name: ____________________

This inquiry will be used to assess whether your child needs to undergo an ENT checkup at school. Please tick items 1-7 if the parents or student finds any of them applicable or just tick 8 if nothing,

☐1. Scheduled to visit an ENT hospital within three months.
(Disease Name: 　　　　　　　　　　　　　　　　　)
☐2. Seems to have poor hearing.
☐3. Having sneezing, runny/stuffy nose throughout the year and finds them bothersome.
☐4. Always opens the mouth.
☐5. Having loud snoring almost every night.
☐6. Having a hoarse voice.
☐7. Having strange pronunciation.
☐8. None of the above 1 to 7 is applicable.

[The boxes below will be filled in by the school, so leave them blank.]

Observations by School (attending or other teachers)	Result of the checkup
☐1. Seems to have poor hearing. ☐2. Often touching the nose. ☐3. Often sniffs. ☐4. Seems to be sleepy during classes, especially in the morning. ☐5. Often opens the mouth. ☐6. Having a hoarse voice. ☐7. Having strange pronunciation. ☐8. Abnormalities on audiometry (☐Right ☐Left ☐Both ☐1000Hz ☐4000Hz) ☐9. Absent for one or more weeks with fevers, throat pains, or the like, in the last school year. ☐10. A report on a detailed examination by an ENT doctor has not been submitted in the last school year.	☐A1 Suspected hearing impairment ☐A2 Earwax Impaction ☐A3 Middle Ear Effusion ☐A4 Chronic Middle Ear Infection ☐B1 Chronic Rhinitis ☐B2 Allergic Rhinitis ☐B3 Sinusitis ☐B4 Nasal Septum Deviation ☐C1 Suspected Adenoid ☐C2 Enlarged Tonsils ☐C3 Tonsillitis ☐C4 Voice Disorder ☐C5 Language Disorder ☐D Others (　　　　　　　　) ☐E No abnormalities

Ear/Nose/Throat Health Questionnaire (For Junior High School Students)

Grade: Class: NO.: Name:

This inquiry will be used to assess whether your child needs to undergo an ENT checkup at school
Please tick items 1-7 if the parents or student finds them applicable or just tick 8 if nothing,

☐1. Scheduled to visit an ENT hospital within three months.
(Disease Name:)
☐2. Sometimes having dizziness or vertigo, other than dizziness while standing up
☐3. Having sneezing, runny nose throughout the year and finds them bothersome.
☐4. Often having a thick runny nose, or feeling mucus dripping down the throat.
☐5. Suffering from frequent stuffy nose.
☐6. Having difficulty in smelling.
☐7. Having a hoarse voice.
☐8. None of the above 1 to 7 is applicable.

[The boxes below will be filled in by the school, so leave them blank.]

Observations by School (by attending or other teachers)	Result of the checkup
☐1. Abnormalities on audiometry (☐Right ☐Left ☐Both ☐1000Hz ☐4000Hz) ☐2. A report on a detailed examination by an ENT doctor has not been submitted in the last school year. ☐3. Checkup is needed. Reason: ☐.Having poor hearing. ☐ Often opens the mouth. ☐ Having strange pronunciation. ☐ Others	☐A1 Suspected hearing impairment ☐A2 Earwax Impaction ☐A3 Middle Ear Effusion ☐A4 Chronic Middle Ear Infection ☐B1 Chronic Rhinitis ☐B2 Allergic Rhinitis ☐B3 Sinusitis ☐B4 Nasal Septum Deviation ☐C1 Suspected Adenoid ☐C2 Enlarged Tonsils ☐C3 Tonsillitis ☐C4 Voice Disorder ☐C5 Language Disorder ☐D Others ( ) ☐E No abnormalities

Year /Month /Date

Dear Parents/Guardians,

Principal's Name:

Results of Ear/Nose/Throat Checkup

Grade: Class: Name:

On the recent checkup, the following diseases with a circle (〇) are suspected. Please have your child examined by an ENT doctor as soon as possible. After the visit, submit the Doctor's Examination Report to the school.

- Earwax Impaction: Earwax has accumulated enough to completely cover the eardrum. Swimming in this condition tends to cause external otitis. Visit an ENT doctor to remove the earwax before swimming lessons start.
- Chronic Middle Ear Infection: The eardrum has a hole, which may cause ear discharge and/or poor hearing. Visit an ENT doctor before swimming lessons start.
- Middle Ear Effusion: The ear discharge and pain may be slight, but hearing becomes poor.
- Suspected Hearing Impairment: Ask the doctor to examine the degree and causes of the hearing impairment.
- Allergic Rhinitis: The main symptoms are sneezing, and runny and stuffy nose. Poor concentration and/or sleep disorder may occur all year round and delay in development of the child may be observed. Hay fever is one kind of this disease.
- Sinusitis: Sinusitis, so called empyema, causes stuffy nose, thick nasal discharge, heaviness of the head, etc.
- Nasal Septum Deviation: Alternate nasal blockage is the characteristic symptom and nose bleeding and heaviness of the head often occur.
- Chronic Rhinitis: Stuffy or runny nose occurs. Chronic Rhinitis may occur subsequent to a cold, and, in some cases, involves slight sinusitis.
- Tonsillitis: Due to the tonsils' chronic inflammation, fevers and throat pain tend to repeat.
- Enlarged Tonsils: Slight breathing disorder and/or difficulty in swallowing large pieces tend to occur. Snoring or sleep apnea may develop as a result.
- Adenoid: The tonsils in the back of the throat are big for this age. Adenoids may cause stuffy nose, snoring, sleep apnea, recurrent middle ear infection, etc.
- Voice/Language Disorder: A hoarse voice or abnormalities in speech is observed.

Doctor's Examination Report

Grade: Class: Name:

Diagnosis

Treatment: (1) Follow up (2) Under treatment (3) Treatment completed (4) Other

Swimming: (1) Permitted (2) Permitted with ear plugs (3) Other

Comment:

Year /Month /Date

Doctor's Name

Date: Y /M /D

Dear Parents/Guardians,

Principal

Urine Test Notice

For the early detection of potential illnesses, the school will administer the following test. A check appears in all relevant boxes.

[Urine Test]

1. Purpose: To detect kidney diseases and diabetes, etc.
2. When to bring urine sample to school: Month/ Day/

   If forgotten, bring it on: Month/ Day/
3. Where to be handed in: ☐Classroom ☐School Infirmary
4. The test is for: All Grades
5. How to prepare a urine sample:

   (1) The sample should be taken on the morning of the urine test, soon after getting up. Do not take the sample as soon as you begin to urinate. Instead urinate a little into the toilet and then urinate into the container.

   (2) Fill the container up to the level of the indicated mark.

   (3) Close the cap tightly and put the container in the bag. (Bag and container supplied by school.)
6. Those who require a second test will be notified.

Exclusion Notice

Grade: Class: Name:

We are requesting that your child temporarily not go to school.

1. Reason
   ☐Influenza ☐Mumps ☐Chicken pox ☐German measles
   ☐Others (☐Streptococcus pyogenes infection ☐)

2. Recommended period of absence
   Beginning from Y /M /D until you get permission from a doctor.

3. Any other relevant information

Date: Y /M /D

Dear Parents,

Principal Seal

Request: Permission to Attend School

Dear Principal,

Disease ☐Influenza ☐Mumps ☐Chicken pox ☐German measles
☐Others (☐Streptococcus pyogenes infection ☐)

Grade: Class: Name:

I have verified the recession of the above infectious disease. I recommend that the school grant permission to attend school beginning from the following date:

Date: Year / Month /Day
Name of the Hospital
Name of the Doctor Seal

*Please send this permission slip with your child to school.

To Parents/Guardians
In order to ensure a fun and meaningful school experience, it is important to care for your child's health. The health care of children with heart diseases is especially crucial. For this reason, we put importance on heart checkups among other school health checkups. We request that all parents/guardians complete this survey, as it is required part of the checkup.
Please circle applicable items in question 1 ~ 4 and fill in all blanks.

Date of Checkup: Y /M /D / Principal:

School:	Grade: Class: No:	Name:	Sex:	Date of birth:

1. Have you experienced any of the following symptoms recently?

a Sudden, increased (double) heart beat for no apparent reason ･･････････････････････････････ (Yes / No)
b Exhaustion from small amounts of exercise ･･････････････････････････････････････ (Yes / No)
c Tight chest pains during exercise ･･ (Yes / No)
d Irregular pulse from time to time ･･ (Yes / No)
e Loss of consciousness while relaxing, during exercise, after exercising ････････････････････ (Yes / No)
f Loss of breath while climbing stairs at regular pace ･･････････････････････････････････ (Yes / No)

2. Have you ever been diagnosed with heart problems in the past?
If yes, please answer questions 1 ~ 4 below. (Yes / No)

1) What was the problem? (Please circle the applicable diagnosis or describe the problem in detail)
a) Congenital heart defect b) Arrhythmia c) Cardiomyopathy d) Cardiac murmur e) ECG irregularity
f) Rheumatic heart disease g) Other: ______________________________

2) When and where did you first learn about this problem?
When? Age: Where? 1) Hospital: 2) School: Grade:

3) Have you recovered since then?
a) No special care was required after a detailed examination. Date of examination: Hospital:
b) Currently undergoing regular examinations.
Hospital: ____ times a year. Classification: A B C D E
c) Unsure. Have not consulted a doctor.

4) Have you ever had heart surgery?
a) Yes → When and Where did you last undergo heart surgery?
b) No → Year: Hospital:

3. Have you ever been diagnosed with Kawasaki disease? ････････････････ **(Yes / No)**
If yes, please answer questions 1 ~ 3 below.

1) When and where were you diagnosed? Age: Hospital:
2) What were the results of the cardiac echo?
a) normal b) temporary swelling of coronary artery c) persistent coronary lesion d) no test conducted
3) What is your present condition?
a) regular hospital medical tests.
Hospital: ____ times a year. Classification: A B C D E
b) Have not been undergoing necessary tests or treatment instructed by the doctor.
c) Tests determined that no special care is necessary. Date determined:
Hospital:

4. Do you have any family or relatives who passed away at an age under 40 due to heart problems or unknown causes?

(Yes / No)

Tuberculosis Checkup Questionnaire

Answered on: Y /M /D

School:	Grade:	Class:	No.:	Name	

Please tick ☑ "Yes" or "No" for each question

	Question	Tick the applicable	
Q1	Has the student suffered from tuberculous diseases (ex. lung infiltration, pleurisy, tuberculous cervical lymphadenitis) in the last two years?	☐Yes Around Y /M /D	☐No
Q2	Has the student been diagnosed as having tuberculosis and taken any preventive drugs in the last two years?	☐Yes Around Y /M /D	☐No
Q3	Are there any family members or lodgers who have had tuberculosis in the last two years?	☐Yes Around Y /M /D	☐No
Q4	Has this student lived abroad for six months or more in total in any foreign countries over the last three years?	☐Yes Around Y /M /D	☐No

Sub-question	If you answered "Yes" for Q4:
4-1	Please provide the names of the countries where the student was living at that time. [ ]

Q5	Has this student been coughing or having phlegm for two or more weeks?	☐Yes	☐No
Sub-question	If you answered "Yes" for Q5:		
5-1	Is the student undergoing any treatment or examination at a medical institute for the coughing or phlegm	☐Yes	☐No
5-2	Has the student been diagnosed with asthma or asthmatic bronchitis?	☐Yes	☐No

If the student is in the 1st grade of elementary school, please answer Q6.

Q6	Has the student received a BCG vaccine? Please answer referring to the vaccination records in the Maternal and Child Handbook (*Boshitecho*) if you have one.	☐Yes	☐No
Sub-question	If you answered "No" for Q6:		
6-1	Why hasn't the student received the vaccine?	☐Tuberculin skin testing was positive.	☐For other reasons.

The box below will be filled in by the school, so leave it blank.

According to the observation of the school doctor, detailed examination for tuberculosis is:	
Required	Not required: Reasons [ ]

[To parents/guardians] If you answered "Yes" to any of the questions Q1 to Q3, please understand and note that your answers will be examined by the public health care center to evaluate the health care status of the student.

Interview Sheet for Tuberculosis Scrutiny

Answered on: Y /M /D

Student's Name		Parent/ Guardian's Name			
Date of Birth	Y /M /D	Grade		Age	
Address				Telephone	
Current health status					
Past tuberculosis history of the student and his/her family members, if any					
Past history of respiratory diseases of the student, if any					

History of Tuberculin Skin Testing	Date: Y /M /D	Interpretation: + - (x mm)
	Date: Y /M /D	Interpretation: + - (x mm)
	Date: Y /M /D	Interpretation: + - (x mm)
	Date: Y /M /D	Interpretation: + - (x mm)

BCG vaccination	☐Has Received ☐Has Not Received
	Last Vaccination Date: Y /M /D

Note:

- In the "Current Health Status" box, please write whether the student has/doesn't have a fever, cough, phlegm, dullness, headache, etc. on the day of examination.
- In the "History of Tuberculin Skin Testing" boxes, please write the dates when the student received tuberculin injections.
  If double erythema appeared then, write its inner diameter in the parenthesis. If blisters etc. appeared, write that fact.
- For the BCG vaccination record during infancy, please refer to the Maternal and Child Handbook (*Boshitecho*), etc.
- Please be sure to bring this Interview Sheet and the Maternal and Child Handbook on the day of examination.

健康⑮

Musculoskeletal Checkup Questionnaire

Grade: Class: No: Name: Male ・ Female

***Please tick ☑ the applicable descriptions/answers to the questions in the heavy-lined boxes.**

Does the student regularly do ballet, dance, or any other sports?
☐No ☐Yes (Sport's Name: Years of Experience: years)

1) Four checkpoints for Scoliosis	Situation/Answer	To be filled in by the examiner
① ② ③ ④	Tick if applicable. ☐① Having uneven shoulder heights. ☐② Having uneven shoulder blade heights or positions. ☐③ The sides of the body trunk curve differently. ☐④ When bending forward, the sides of the back appear different in height.	[Abnormal Findings] ☐Having abnormalities
2) Please tick ☑ the applicable answers.		
When bending forward or backward, does the lower back hurt?	[Bending Forward] ☐① It does not hurt. ☐② It hurts. [Bending Backward] ☐① It does not hurt. ☐② It hurts.	[Abnormal Findings] ☐Having abnormalities
Can the student stand on one leg (left/right) for 5 seconds without losing balance or swaying?	[On the Left Leg] ☐① Yes, without problems. ☐② The body sways. ☐③ Can't keep standing. [On the Right Leg] ☐① Yes, without problems. ☐② The body sways. ☐③ Can't keep standing.	[Abnormal Findings] ☐Having abnormalities
Can the student squat with the feet flat on the ground?	☐① Yes. ☐② No.	[Abnormal Findings] ☐Having abnormalities
When raising both arms straight up alongside the ears, can both arms touch the ears?	[Left Arm] ☐① Yes ☐② No. [Right Arm] ☐① Yes. ☐② No.	[Abnormal Findings] ☐Having abnormalities
With the palms up, can each elbow be fully straightened and fully bent till fingers touch shoulders ?	[Left Arm] ☐① Yes, without problems. ☐② Can't be fully bent. ☐③ Can't be fully extended. [Right Arm] ☐① Yes, without problems. ☐② Can't be fully bent. ☐③ Can't be fully extended.	[Abnormal Findings] ☐ Having abnormalities
3) Are there any musculoskeletal symptoms?		
If there are any symptoms in the bones, joints, muscles, etc. please put a circle (○) at the location and explain them in the right box.	[Symptoms]	[Abnormal Findings] ☐ Having abnormalities

4) If there are any other concerns regarding the body, legs, or arms, please write here.

5) Does the student undergo treatment related to the above questions?
☐No・☐Yes (Disease Name:)

*** The part below will be filled in by the school, so leave it blank.**

[Scrutiny is: Required ・ Not Required]

Report of the Scrutiny Results

Date: Year /Month /Day

Parents/Guardian

Principal:

According to the results of the Musculoskeletal Checkup, it is advised to visit an orthopedist to undergo scrutiny. After the visit, submit the Doctor's Examination Report to the school.

*Note: Please be sure to bring this Musculoskeletal Checkup Questionnaire and the health insurance card of the student, etc. (if applicable) to the hospital/clinic.

Doctor's Examination Report

Diagnosis ( )

Doctor's Advice ( )

Date: Year /Month /Day

Surgeon's Name: