PEDIATRICS

Name **Male ・ Female / Temperature** **℃**

Date of birth **year** **month** **day / Weight** **Kg**

Address 〒

Phone **Brothers &Sisters** **Yes / No (Age)**

School Name **Childcare / Kindergarten / Elementary school**

①What are your symptoms?(your child)

When did the symptoms begin? Please write.

fever（ ） runny nose/stuffy nose（ ） sore throat（ ）

cough（ ） vomiting（ ） diarrhea( ) stomach ache（

rash（ ） headache（ ） others（ ）

②Are there any diseases prevalent around you? Please write.

・Strep throat ・Adeno virus ・RS ・Human metapneumovirus ・High fever

・Vomeiting/diarrhea ・Influenza ・SARS-CoV-2 ・Chicken pox ・Mumps ・Others(

③Have you ever had a seizure？ Yes（ times） ・No

④Do you have any food or medication allergies?

Yes（ ） ・No

⑤What illnesses have you ever noted?

・Asthma ・Pollen allergy (Hay fever) ・Allergic rhinitis ・Atopic dermatitis

Others（ ）

⑥Please let me know if any allergy tests come back positive.

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⑦Does anyone in your family have allergies？ ・Yes ・No

⑧What type of medicine is best?

syrup(Up to 3 years old) ・ powder ・ tablet or capsule