

Parent/Guardian

About applying for

- **School placement counseling and guidance (for new 1st grade students) or**
- **Educational counseling and guidance (for current 1st to 9th grade students)**
at the Yokohama City Comprehensive Center for Special Needs Education.

If you would like to apply for school placement counseling (for children who are planning to enter elementary school in the next school year) or educational counseling and guidance (for children who are already enrolled in elementary school, junior high school, or compulsory education school) at the Yokohama City Comprehensive Center of Special Needs Education, please fill out the designated application form.

For counseling and guidance about school placement or plans to transfer

Please note that applications by phone or fax are not accepted.

[Notes] When filling out the form, please use a ballpoint pen and write in block style.

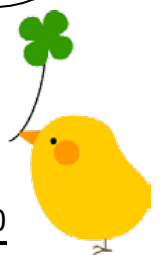
- You can leave the fields blank if they do not apply to you.
Please provide as much information as you can about your child's upbringing.
- If you have the most recent test results from another institution, please enclose a copy to the extent you are comfortable with.
- The date of the consultation will be decided depending on the child's situation.
Please note that applications will not be accepted in order of application.
- When the consultation date is decided, we will notify the parents by mail in the case of school placement counseling and guidance, or in writing by way of the school in the case of educational counseling and guidance.
- The information you provide will be used to provide consultation and education. It will not be used for any other purpose.
- Please submit your application on A4-sized paper. Do not use staples.

If you have any questions, please contact us.

ADDRESS: 240-0044 845-2, Bukkocho, Hodogaya-ku, Yokohama City

Special Support Educational Consultation Division, Board of Education Secretariat

(Yokohama Comprehensive Center of Special Needs Education) TEL: 045-336-6020



APPLICATION - FORM 1

Yokohama City Comprehensive
Center of Special Needs Education

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Application for

School Placement Counseling & Guidance (for children entering 1st grade) OR
Educational Counseling & Guidance (for current elementary or junior high school students)

2025-2026 School year

受付日時印 <small>【記入しないでください】</small>
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Date of Application _____ / _____ / _____
Year Month Day

Applicant's Name _____

Relationship to the child Father / Mother / Other _____

Furigana (katakana)					
Child's Name			Date of Birth: _____ / _____ / _____		
			Age: ____ Gender: Male / Female		
Furigana (katakana)					
Parent or Guardian's Name	Father / Mother / ()				
Address (in Japan)	Postal Code (〒 —)				
	Plans to move (No / Yes) Date New Address				
Phone Number	Cellphone ()		Father · Mother · Other()] [] Check (<input checked="" type="checkbox"/>) best from 9 a.m. to 5 p.m.
	Home phone ()] []		
Inconvenient meeting days and times	<u>Inconvenient</u> days and time ※ We may not be able to meet your request.				
	Mon	Tue	Wed	Thu	Fri
	am / pm	am / pm	am / pm	am / pm	am / pm

< For School Placement Consultation > (children entering 1st grade)

< For Educational Consultation > (current elementary or junior high school students)

Kindergarten (Youchien)	_____ < days/wk >
Special Needs School (Infant Section)	_____ < days/wk >
Daycare / Nursery School (Houikuen)	_____ < days/wk >
Rehabilitation (Ryo-iku) Center, etc.	_____ < days/wk >
	Child Development Support Office _____ < days/wk >
Your Local Area Elementary School	School: _____ Elementary School Consultation Date _____ / _____

	School _____
Current School	Grade _____ Class _____
	<input type="checkbox"/> Special Needs Class <i>kobetsushien-gakkyuu</i>
	<input type="checkbox"/> General Class <i>ippan-kyuu</i>
	Homeroom Teacher: ()
	Did you consult with the school about your child? (Yes / Not Yet / Scheduled <Date / >)
	Does your child go to a special support services classroom (tsuu-kyuu)? School Name: ()
	(Emotional · Hearing · Speaking · Seeing)
	Using "Heartful Room or Space" (Yes / No)

特別支援教育総合センター使用欄 (Please do not fill out this part.)

相談月日	月 日 ()	午前・午後	時 分	担当 ()	
発達検査月日	月 日 ()	午前・午後	時 分	担当 ()	
変更月日	月 日 ()	午前・午後	時 分	担当 ()	
発達検査月日	月 日 ()	午前・午後	時 分	担当 ()	
①入力	②入力チェック	③相談員確認	④発送	⑤変更発送	変更理由 ①保護者の希望 ②キャンセルによる延期 ③その他 ()
				要 不要	

APPLICATION - FORM 1

◎ About the consultation

<p>(1) Purpose of consultation Check all reasons that apply.</p>	<p>【School Placement Consultation】 (children entering 1st grade) <input type="checkbox"/> Parent / Guardian's request <input type="checkbox"/> Local school principal's recommendation 【Educational Consultation】 (current elementary or junior high school students) <input type="checkbox"/> Parent / Guardian's request <input type="checkbox"/> School's recommendation <input type="checkbox"/> Plan to move to Yokohama from another city</p>																		
<p>(2) Preferred class or school Check all classes/schools that apply.</p> <p>※If your only preference is “Special needs class” you may be able to enroll without coming to the Center if certain conditions are met. For more information, please consult each school.</p>	<p><input type="checkbox"/> General class (<i>Ippan-kyu</i>) <input type="checkbox"/> Special needs class (<i>Kobetsushien-gakkyu</i>) <input type="checkbox"/> Special support services classroom (<i>Tsuu-kyu</i>) Impairment: <input type="checkbox"/> Emotional <input type="checkbox"/> Hearing <input type="checkbox"/> Speaking <input type="checkbox"/> Seeing <input type="checkbox"/> Special support education school (SSES) Impairment: <input type="checkbox"/> Intellectual <input type="checkbox"/> Physical <input type="checkbox"/> Hearing <input type="checkbox"/> Seeing Schools you visited ()</p>		<p>Planning to take exam for private or national SSES. (Yes / No)</p>																
<p>(3) Interpreter at consultation</p>	<p>Unnecessary / Necessary (Language: child / guardians) (Japanese only) Sign Language interpreter (Unnecessary / Necessary)</p>																		
<p>(4) Consultation history</p>	<p>None / Yes (Date: Year / Month) ※Has your child's name changed? (Yes. Previous name:)</p>																		
<p>(5) Has your child ever had a developmental test (an IQ score) outside of the center?</p> <p>→If you have a paper copy of your developmental test results, please send a copy with your application. (We will use it for reference.) ※Please be sure to contact the Center in advance if you take a developmental test after you have applied.</p>	<p style="text-align: center;">None • Yes</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%;">Facility</td> <td colspan="3"></td> </tr> <tr> <td>The latest date</td> <td>Year</td> <td>/</td> <td>Month</td> </tr> <tr> <td>Test Name</td> <td colspan="3">Tanaka – Binet V / WISC-IV Others :</td> </tr> <tr> <td>Results</td> <td colspan="3">(IQ score, etc.)</td> </tr> </table>			Facility				The latest date	Year	/	Month	Test Name	Tanaka – Binet V / WISC-IV Others :			Results	(IQ score, etc.)		
Facility																			
The latest date	Year	/	Month																
Test Name	Tanaka – Binet V / WISC-IV Others :																		
Results	(IQ score, etc.)																		
<p>Plans to take a developmental test</p>	<p>Date: Year / Month</p>	<p>Facility:</p>	<p>Test Name:</p>																
<p>【Agreement】 <u>Be sure to fill out this form.</u> ※The materials submitted will be handled properly in accordance with Yokohama City Information Disclosure, Yokohama city's Personal Information Protection Ordinance.</p> <p>1 We may request test results from a treatment center or child consultation center. (Agree • Disagree) 2 We may, if required, provide results from tests done at the Center to that division. (Agree • Disagree) 3 We may use the results during consultations at the Center. (Agree • Disagree)</p> <p style="text-align: center;">Date: ____ / ____ / ____ Parent or Guardian's signature _____</p>																			

◎ Disability Certificates

<p>Certificate of Intellectual Disability (<i>Ai-no-Techo</i>)</p>	<p>The 1st Grant The present Grant The next Grant</p>	<p>Date: Year / Month / Day Date: Year / Month / Day Date: Year / Month / Day</p>	<p>< A1 A2 B1 B2 > < A1 A2 B1 B2 > < A1 A2 B1 B2 ></p>
<p>Physical Disability Certificate</p>	<p>The 1st Grant The present Grant The next Grant</p>	<p>Date: Year / Month / Day Date: Year / Month / Day Date: Year / Month / Day</p>	<p>Disability Visual / Hearing / Limbs</p>
<p>Mental Disability Certificate</p>	<p>The 1st Grant The present Grant The next Grant</p>	<p>Date: Year / Month / Day Date: Year / Month / Day Date: Year / Month / Day</p>	

APPLICATION - FORM 1

◎ **Regarding Medical Care, etc.**

Has your child ever visited a clinic or hospital? (Yes / No)

<p>Names of Medical Institutions</p> <p>※Ryoiku-Center, etc</p>	
<p>Diagnoses</p> <p>(date of diagnosis)</p>	<p>Ex) Autism Spectrum Disorder (2019/01/25)</p>
<p>Medicine</p> <p>(Name, Dosage, Times)</p>	
<p>【Medical History】 Institutions, Date, Purposes</p>	
<p>【Medical Plans】 Institutions, Date, Purposes</p>	

◎ **Cohabiting family members** ※Please check and write the number of each person

- father
 mother
 older brother
 older sister
 younger brother
 younger sister
 others () Ex) 2 older brother

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©Child's Development ※Fill out the form with reference to your mother and child's handbook.

(1) Length of pregnancy	weeks
(2) Weight at birth	grams
(3) When was your child able to hold up their head?	Age: years months
(4) When did your child stand while holding on?	years months
(5) When was your child able to walk?	years months
(6) When did your child start toilet training?	years months
(7) When did your child stop wearing diapers?	years months
(8) Has your child ever been seriously ill?	years months (illness:)
(9) Has your child ever had convulsions?	years months
(10) Has your child ever had a brain scan?	Yes (years months) / None
(11) Has your child ever been in hospital for 6 months or longer?	years months (illness:)
(12) Were any points raised about your child at their 18-month-old checkup? Yes / No (Points raised: _____) (Actions taken: _____)	
(13) Were any points raised about your child at their 3-year-old checkup? Yes / No (Points raised: _____) (Actions taken: _____)	
(14) Please circle all conditions that apply to your child. <div style="display: flex; flex-wrap: wrap; padding: 10px;"> <div style="width: 33%;">① Allergies</div> <div style="width: 33%;">② Asthma</div> <div style="width: 33%;">③ Prone to diarrhea</div> <div style="width: 33%;">④ Prone to constipation</div> <div style="width: 33%;">⑤ Prone to vomiting</div> <div style="width: 33%;">⑥ Prone to headaches</div> <div style="width: 33%;">⑦ Prone to fever</div> <div style="width: 33%;">⑧ Prone to a cold</div> <div style="width: 33%;">⑨ Prone to tinnitus</div> </div>	
Do you have any other concerns about your child's health?	

APPLICATION - FORM 1

◎Your child's current condition

Daily Life	Eating	Independent • Partially independent • Needs help • Incapable
		Eccentricities None • Yes ()
		Allergies None • Yes ()
		Style of food Regular • Sliced • Mashed • Other ()
		< Details >
Dressing	Independent • Partially independent • Needs help • Incapable	
	< Details >	
Toilet	Independent • Partially independent • Needs help • Incapable	
	< Details >	
Language (expression)	Easily • Limited (2 or 3 words) • Limited (single words) • Incoherent words • Incapable	
	When did they start speaking? Age: years months	
	When did they start speaking 2 to 3 word sentences? Age: years months	
	Do you have any concerns about the current spoken language of your child? Yes • No	
	Please describe in detail about the language (expression).	
Language (understanding)	Easily • Limited (2 or 3 words) • Limited (single word) • Incoherent words • Incapable	
	Please describe what you are doing to communicate to your child.	
Has your child ever lived in a non-Japanese language environment? Yes • No <input checked="" type="checkbox"/> Yes → Term (Age: _____ ~ Age: _____) Please let us know the status of your child's communication in Japanese. <div style="border: 1px solid black; height: 40px; width: 100%;"></div>		

Movement	Independent • Partially independent • Needs help • Incapable		
	Please describe how your child gets around and any considerations you need to make for your child.		
Group Activities	Possible • Partial participation (possible with support) • Difficult		
	If you circled "Partial participation (possible with support)" or "Difficult", please describe your specific situation.		
Vision	Vision	Unaided eyes R () • L () Corrected vision R () • L ()	Uses glasses Yes • No
	Color-blindness	Yes • No	
	Strabismus	Yes • No	
	Diseases, etc.		
	Please describe any other concerns about your child's vision.		
Hearing	Normal • Deafness		
	Unaided ears R () • L () Corrected hearing R () • L ()		Wears hearing aid Yes • No Cochlear implant Yes • No
	Please describe any other concerns about your child's hearing.		
Dominant Hand	Right-handed • Left-handed • Undifferentiated		
Medical Care			
Favorite things to do	Details.		
Interests			
Things your child is good at	Details.		
Strengths, etc.			

APPLICATION - FORM 1

Do you have any concerns about your child's current condition? Yes • No

If "Yes", please check the appropriate box for each of the following

① It's hard to make eye contact.	Often • Sometimes
② He/she is very shy.	Often • Sometimes
③ He/she may shout loudly and out of place.	Often • Sometimes
④ Memorizes only certain things, such as kanji, symbols, station names, etc.	Often • Sometimes
⑤ Makes vigorous movements, is restless and acts impulsively.	Often • Sometimes
⑥ Hits and bites parts of his/her own body.	Often • Sometimes
⑦ Puts non-food items in his/her mouth.	Often • Sometimes
⑧ He/she doesn't understand instructions and restrictions.	Often • Sometimes
⑨ Unable to act in accordance with his/her surroundings.	Often • Sometimes
⑩ Unable to act in response to location or changes.	Often • Sometimes
⑪ Flutters his/her palms or paper.	Often • Sometimes
⑫ He/she has an obsession with certain things and matters. (What kinds of things?)	Often • Sometimes
⑬ He/she is clumsy or awkward.	Often • Sometimes
⑭ He/she repeats the things he/she or others say.	Often • Sometimes
⑮ Aggressiveness.	Often • Sometimes
⑯ He/she has sensory overload. (What kinds of things cause it?)	Often • Sometimes

◎ Please describe what you would like to discuss and what is on your mind.

※The materials will be handled properly in accordance with Yokohama City Information Disclosure, Yokohama city's Personal Information Protection Ordinance.