Infants Temporary Custody Application Form

Application Date: ／ ／	Registration Number	

Child's Name	(nickname)		
Primary Care Doctor	Hospital TEL:	Hospital TEL:	
Medical History	Fever Convulsions (y m) Convulsions (y m) Asthma (y m) Mumps (y m) Chicken Pox (y m) German Measles (y m) Others ( )	Hospitalized	No Yes Name of desease; ( ) (y m)

Lifestyle habits

Defecation	time/day	Defecation desire	Tells you ・ Sometimes tells you ・ Does not tell you
Urination	time/day	Urge to urinate	Tells you ・ Sometimes tells you ・ Does not tell you
Habits and signs when falling asleep	Nap(hour (s)) Sleep alone ・ Sleep together Habits of sleeping ( )		
Favorite games,toys,music, characters			
Personality・Habits (etc)	Shy(No ・ Yes)→ to what kind of person?( )		
Other things to keep in mind			

Meals

Amount of food/ How to eat	Amount (Eat a lot ・ Normal ・ Doesn't eat much) Cutlary (Chopsticks ・ Spoon ・ Fork ・ Hands) Independent eater ・ Sometimes needs assistance ・ always needs assistance	
Feeding contents	Powdered milk ・ Breast milk ・ Mix	The required time for feedingv (min)
	Amount ㎖	The number of feeding in a day (times/day)
Solid Food	Started months	The number of solid foods in a day (times/day)

Allergies

Allergy contents		How symptoms cccur	Diagnused by a physician
Food	No ・ Yes ( )	When eat ・ When touch	No ・ Yes
Medicine	No ・ Yes ( )		No ・ Yes
Enviornment	No ・ Yes (Tick ・ House dust ・ Animal)	When touch an aniimal ・ When contact with a pet owner	No ・ Yes
Giving Medication	No ・ Yes ⇒	Name of Medicine ( )	

Check list of documents	☐ My Number card ☐ Health Insurance Eligibility Certificate ☐ Child Medical Assistance Certificate or Welfare Medical Certificate
(Remarks)	