Infants Temporary Custody

Application Form

Application Date: / /	Registration Number	

Child's Name	(nickname)			
Primary Care Doctor	Hospital TEL:		Hospital TEL:	
Activities of daily life				
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	Yes Name of Disease No (y m)
Defecation	time/day	When have the urge to go… Tells you	Sometimes tells you	Does not tell you
Urination	time/day	When have the urge to go… Tells you	Sometimes tells you	Does not tell you
Habits or signs of going to sleep	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 we should be careful about				
Meals				
Amount and method	Amount (Big eater ・ Normal ・ Light eater) Utensils (Chopsticks ・Spoon ・Fork ・Hands) Independent eater ・ Tries tobe an independent eater ・ Dependent eater			
Providing milk	Powdered milk ・ Breast milk ・ Mix	Time milk is given at one feeding (min)		
	Amount ml	Number of times milk is given (times/day)		
Weaning	Started m.	Number of times weaning(times/day)		
	Contents (Mashed food ・Soft food ・ Same as adults)			

Allergies			
Allergy contents		How symptoms occur	Diagnused by a physician
Food	None ・ Yes( )	When eat When touch	No ・ Yes
Medicine	None ・ Yes( )		No ・ Yes
Enviornment	None・Yes(Flea ・House dust ・ Animal)	When touch ananimal When around a pet owner	No ・ Yes
Giving Medication	None・Yes	Name of Medicine( )	

Submit Docment Check list	☐ Child Health Insurance card ☐ Infant Medical Certificate or Welfare Medical Certificate ☐ Mother and infant (Boshi) Notebook (A copy of these documents will be made)
(Remarks)	

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