

Infants Temporary Custody Application Form

Application Date: / /	Registration Number
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Child's Name	(nickname)		
Primary Care Doctor	Hospital	Hospital	
	TEL:	TEL:	
Medical History	Convulsions (y m) (y m) (y m) (y m) (y m) Others ()	Hospitalized	No Yes Name of disease; (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 feeding (min)	
	Amount ml	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 occur	Diagnosed by a physician
Food	No · Yes ()	When eat · When touch	No · Yes
Medicine	No · Yes ()		No · Yes
Environment	No · Yes (Tick · House dust · Animal)	When touch an animal · When contact with a pet owner	No · Yes
Giving Medication	No · Yes ⇒	Name of Medicine ()	

Check list of documents	<input type="checkbox"/> My Number card <input type="checkbox"/> Health Insurance Eligibility Certificate <input type="checkbox"/> Child Medical Assistance Certificate or Welfare Medical Certificate
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(Remarks)	
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Minato City Kosodate-Hiroba Appy Akasaka