## Infants Temporary Custody

Application	Form	Application Date:	/	/	Registration Number				
Child's Name	(nickname)								
Primary Care Doctor	Hospital 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( ) Yes Name of Disease No ( y m)								
Defecation	time/day	When have the urge to g	;o··· Te	lls you	Sometimes tells	you D	oes not t	tell you	
Urination	time/day	When have the urge to g	;o··· Te	lls you	ou Sometimes tells you I			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									
		Me	als						
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 Amount ml				milk is given at one feeding (min) ber of times milk is given (times/day)				
	Started m. Number of times					<u> </u>	times/		
Weaning	Contents (Mashed food • Soft food • Same as adults )								
		Alle	gies			<del>,</del>			
	Allergy contents	s	How symptoms occur				Diagnuse physiciar	•	
Food	None • Yes(	)	When e	eat Whe	n touch		No • \	Yes	
Medicine	None • Yes(	)					No · \		
Enviornment		ouse dust · Animal)		uch ananimal	When around a p	oet owner	No • \	í es	
Giving Medication		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)									