INFANT INFORMATION

Name of Child:	DOB:	Age:	Sex:

(For some questions, answers are underlined. Please select the right answer by circling it.)

Eating Behavior:

Is your baby: bottlefed, breastfed How often?:_____

Number of bottles I will be giving the baby each day? (estimate):_____

How many ounces? _____How does he/she drink it? Warm, Cold

How do you heat the bottle? Stove, microwave, crockpot

Name of formula given: _____

Will you be bringing the bottles ready made, or will we need to make them? _____

Any special feeding instructions:

_____

Does the baby need to stop feeding to burp, be changed, etc.? Yes, No

Is the baby on a schedule? Yes, No

Feeding Schedule

_____

_____

How is child fed? lap, high chair, infant seat, other _____

Does child use bottle, breast fed, cup, cup w/lid

Which of these does the child drink? Formula, milk, breast milk, juice, baby food only

Brand _____ Quantity _____ Frequency _____

Table foods (please specify if limited) _____

Any food allergies or special needs?

_____

Any history of colic?

_____

Sleeping Behavior:

Rest time/s _____

What does he/she take to bed (blanket, bottle, pacifier, etc.)

_____

Rest time procedures

_____

What is his/her mood upon awakening?_____

Typically sleeps in: crib, bed

Toilet Habits:

Do you use: desitin, powder, special wipes, other _____

Is diaper rash a problem? _____ If so, how do you treat it? _____

Miscellaneous:

Does child have an "unsettled" time? _____ When? _____

What do you do? _____

How does child relate to strangers? _____

What if anything do you do for teething?_____

Do you allow the baby to have a binkie (pacifier)?: Yes, No

If so when?: just at bedtime, just when fussy, anytime

Has baby been exposed to other children often? Yes, No

Are any medications given regularly?: _____

Have you made any arrangement for care when I am unable? Yes, No

What time does the baby awaken?:_____

What time does your baby go to sleep at night?:_____

Does he/she sleep through the night? Yes, No

Any security toy or blanket for nap time? Yes, No What?: _____

Does your child have any security objects that help him/her feel better when upset?

_____

By signing this form, you verify that all of the information provided is correct to the best of your knowledge.

Father/Guardian's Signature	Date
Mother/Guardian's Signature	Date
(Your Daycare name goes here)	Date