

GETTING TO KNOW YOUR INFANT

Please fill out this form for your child ages 0 to 18 months. It will help me get to know your child better.



Child's Name: _____

Child's Date of Birth: _____ Place of Birth: _____

____ Pre-Mature Birth ____ Full-Term Child's Birth Weight: _____ Home birth OR Hospital

Child's General Mood: (*Happy, fussy, colicky*): _____

Has child stayed with anyone else besides parents? YES / NO If so who? _____

Is child Bottle or breast-fed? _____ If using both, when do you use bottle vs. breast? _____

How do you give bottle (*room temp, warmed, or cold*) _____

If you warm the bottle, what procedure do you use to warm bottle? _____

Does the child hold his or her own bottle? _____

Is child on formula or milk? _____ What kind of milk or formula do you use? _____

Is child on baby cereal? _____ List the kinds you use: _____

Is child on strained or other baby foods? _____ List the varieties you use (*fruits, veggies, etc.*) _____

Food likes: _____

Food dislikes: _____

List amounts of food, types of food and times your child usually eats below:

Breakfast _____

Lunch _____

Snack _____

Will your child have a bottle or breast fed before arriving? _____

Will your child need breakfast upon arriving at the center (*8:30AM*) _____

Does your child use a pacifier? _____ When? _____

Does your child need a special comfort item to sleep with? _____ What is it? _____

Does your child sleep through the night? _____ If not how often do they wake: _____

Routine upon waking up (*feed, rocking, change etc.*) _____

When time does your child wake in the morning? _____

What time does your child go to sleep at night? _____

When does your child nap morning? _____ Afternoon? _____

Please list any other important information or special instructions on the care of your child below:

Parent/Guardian Printed Name

Date

Parent/Guardian Signature