Infant and Toddler Information / Concerns

Child's Name_____ Date:_____ /_____ /_____

Birth Date:_____ Hours of Enrollment _____

Eating Patterns:

Check each of the following that pertain to your child:

Breast fed ( ) Bottle ( ) Warmed ( ) Cup ( ) Spoon ( ) Fork ( ) Bowl ( ) Plate ( )

Fingers ( ) Strained Foods ( ) Baby Foods ( ) Table Foods ( ) Formula ( ) Whole Milk ( )

Other_____

Food Likes_____ Food Dislikes_____

Allergies_____ Feeding Problems _____

Eating Schedule (times, types, and amounts)

Breakfast_____ Mid-Morning Snack_____

Lunch_____ Afternoon Snack_____

Dinner_____

Sleeping Patterns:

Check each of the following that pertain to your child:

Sleeps Well ( ) Doesn't Sleep Well ( ) Back ( ) Stomach ( ) Pacifier ( )

Security Blanket/Toy ( ) Bottle ( ) Rocked ( )

Napping Schedule (times, amounts)

Nights_____ Morning Naps_____ Afternoon Nap_____

Has your baby shown any sleeping problems?_____

_____

Does your baby usually cry before going to sleep? _____

Does your baby cry when waking up? _____

Is your baby accustomed to absolute quiet when sleeping? _____

Language Development:

How does your child tell what he/she wants?

Gestures: _____

Words: _____

Sentences: _____

Medical Concerns:

Please list all allergies and their reactions:_____

_____

Has your child had any injuries, operation, or health related problems that we need to be aware of?

_____

Has your child had any serious or reoccurring illness? _____

_____

Are there any activities your child cannot participate in? _____

_____

Personality:

How would you describe your child's personality? _____

_____

What do you enjoy most about your child? _____

What do you find troublesome about your child? _____

How does your child act when tired? _____

What 'cues' should we look for? _____

Are there any situations that frustrate or anger your child? _____

Diapering:

WE WILL ONLY USE DISPOSABLE DIAPERS!!!

Approximately how many times do you change your baby between 7:30 AM and 5:30 PM? _____

Does your baby have loose stools? _____ Normal? _____ Hard? _____

We will help with toilet training when you feel your child is ready for this milestone. We will work together with you to come up with a plan that is best for your child. We would like to know your personal philosophy regarding this matter. (Normally we start this process at 18 months and up.):

_____

_____

_____

_____

_____

Developmental Growth:

Age at which your baby:

Crept on hands and knees_____ Sat Alone _____ Walked Alone_____

Began Eating Finger Foods_____ Said First Word _____

Used a Spoon Well _____ Used a Training Cup _____

Used a Regular Cup_____ Combined Two Words _____

General Info:

What do you consider essential to a quality Day Care Program for your child? _____

_____

_____

_____

_____

_____

If there are any other special instructions or comments that you would like to add you may do so on the lines below and continue onto the back if needed: _____

_____

_____

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