Infant Information Questionaire

Child's Name | Date of Birth | Date of Enrollment

Parent's Name: | Phone No

Health

Is your child allergic or extra sensitive to any brand of diaper, wipe, cream, detergent, etc? Yes☐ No ☐
If yes, please explain _____

Does your child have an existing illness? Yes☐ No ☐
If yes, please explain _____

Has your child had a serious illness, injury, or hospitalization during the past 12 months? Yes☐ No ☐
If yes, please explain _____

Is your child taking any medication? Yes☐ No ☐
If yes, please explain _____

Will it need to be administered while he/she is in care? Yes☐ No ☐

Is the medication prescribed for continuous use? Yes☐ No ☐

Are there any side effects we should be aware of? Yes☐ No ☐
If yes, please explain _____

Does your child have problems with ear infections? Yes☐ No ☐

Does your child have tubes in his/her ears? Yes☐ No ☐

Activities and Behavior

What activities do you and your child like to do together? _____

What does your child like to do when he/she is playing alone? _____

When your child gets upset, what helps him/her calm down? _____

Does your child use a pacifier? Yes☐ No ☐
If yes, when: _____

Do you rock your child to sleep? Yes☐ No ☐

Does your child have a security item? Yes☐ No ☐
If yes, please explain _____

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How is your child most comfortable when he/she is napping? _____

What are your child's nighttime sleeping habits? _____

What are your child's daytime sleeping habits and schedule? _____

Has your child ever attended a daycare? Yes☐ No ☐

What would you like your child to learn or experience while at daycare?

Tell me about your family (i.e. child's parents, siblings, grandparents, and other extended family)

Additional Comments: _____

I verify that the above assessment was discussed with the parent(s)

_____ _____

Signature of Director/Person in Charge Date

I verify that the director appropriately relayed the information concerning my child's assessment.

_____ _____

Signature of Parent Date