Infant Information Form

Child's Name_____ Birthdate: _____

Parent's Signature: _____

Email Address: _____ Best Phone # to call: _____

Teacher's Signature: _____ Child's Class: _____

(Please fill out front and back)

1. Please describe your child's personality.

2. What types of activities does your child enjoy?

3. How do you feel your child will adjust to the infant room?

4. What things do you find help to calm your child when he or she is upset?

5. What are your child's favorite toys?

6. What kinds of previous experiences has your child had with other children?

7. Describe your family's cultural background, home language, family traditions, and customs.

8. Were their any unusual circumstances that occurred during your child's birth, i.e., premature, complications?

9. Does you child seem well most of the time? Yes / No

10. Is your child taking any medications currently? Yes / No and Why?

11. Did your child have as many as three ear infections in the last year? Yes / No

12. Are you concerned about your child's hearing? Yes/ No

13. Are you concerned about your child's eyes or vision? Yes / No

14. Has your child ever been seen by a medical specialist? Yes / No and Why?

15. What arrangements have you made if he/she becomes ill at the center?

16. Does your child have any handicaps / delays? Please describe.

17. Other illnesses or diseases? Please describe.

18. Has your child ever been hospitalized? Yes / No Please Describe.

19. Has your child had any of the following? Please circle. Head Injury / Seizures / Trouble Breathing / Allergies (eczema, hives, medications, wheezing, food intolerances, asthma, insect bites)

20. Do you have any specific ways of helping your child go to sleep? Describe.

21. Does your child cry when going to sleep?

22. What is your child's present sleep schedule?

Nighttime from _____ to _____
Morning Nap from _____ to _____
Afternoon Nap from _____ to _____

23. Does your child prefer to sleep on his/her stomach? Sid? Back? (See DHS Alternative Sleep Position Form)

24. Does your child use a pacifier?

25. Does your child have a special blanket?

26. Does your child need a special toy to sleep?

27. Is your child breast fed or bottle fed?

Type of bottle: _____ Type of nipple: _____ Type of Formula: _____

28. Does you baby need to be burped? Yes / No

29. What is your child's current eating schedule? (Please specify amounts)

	Food	Milk / Formula
Breakfast:	_____	_____
Snack:	_____	_____
Lunch:	_____	_____
Snack:	_____	_____

30. Does your child have any feeding issues? Please describe.

31. How frequently does your child have bowel movements?

32. Does your child frequently have diaper rash? If so, how is it treated?

33. It is an easier transition for your child if they can sleep in a crib and take a bottle. How do you foresee your child being able to do each of these?