Getting to Know Your Infant

Child's Name: _____ Date of Birth: _____

Mood: Is your child generally – *Happy Fussy Colicky other*? _____

Does your child have any known allergies? _____

Does your child take in prescription medications? *Yes or No*

If yes, list here please: _____

FEEDING

What does your child drink? (Circle one) *Formula Breastmilk Whole Milk Combination*

If formula, what brand of formula? _____

How do you give the bottle? (Circle one) *Room Temp Warm Cold*

Does your child hold his or her own bottle? *Yes or No*

Does your child eat . . .? (Circle all that apply) *Baby Cereal Baby Food Whole Foods*

Please list foods your child typically likes _____

Please list any foods your child dislikes _____

Please list any foods your child ***cannot*** have _____

YOUR CHILD'S ROUTINE

Breakfast Time: _____ Amount of food/formula_____

Morning Nap Time Frame: _____

Morning Snack/Feeding Time: _____

Lunch Time: _____ Amount of food/formula_____

Afternoon Nap Time Frame: _____

Afternoon Snack/Feeding Time: _____

Does your child have any comfort items? If so, please list _____

Does your child use a pacifier? If so, when? _____

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OTHER IMPORTANT INFORMATION WE SHOULD KNOW

_____

_____

_____

_____

_____

_____

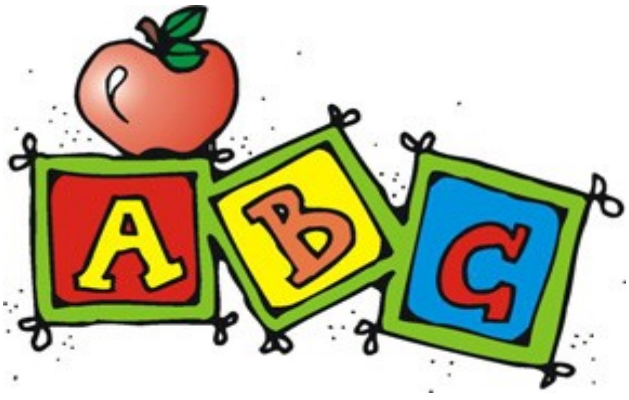
_____

_____

Signature _____

Relationship to Child_____

Date_____



Getting to Know Your Toddler

Child's Name: _____ Date of Birth: _____

Nickname: _____

Child's Information

What is your child's typical mood? (Circle one) *Happy* *Fussy* *Other*: _____

Does your child have any specific fears? *Yes or No* If so, what? _____

Does your child have any speech, hearing or visual problems? If so, which _____

Does your child have any known allergies? If so, to what?

_____

Does your child have any play or activity restrictions? If so, in what way?

_____

Feeding Routine

Please list the amounts of food, types of food and times your child usually eats below:

- Breakfast: _____
- Lunch: _____
- Snack: _____

Does your child eat with a _____ Spoon _____ Fork _____ Hands (Check all that apply)

Does your child drink with _____ Bottle _____ Sippy Cup ____ Regular (Check all that apply)

What kind milk does your child drink? _____

Toileting

Is your child Potty trained? *Yes or No* If so, please describe your toiling schedule and words or phrases your child may use when he/she has to use the Potty:

_____

_____

_____

_____

Getting to Know Your Toddler

Napping

Please list the times your child usually sleeps below:

Morning _____

Afternoon _____

Family Information

Are there any family members' names your child uses frequently? If so, list name and relationship:

_____

_____

Is there any additional information you would like us to know about your child? If so, please list below:

_____

_____

_____

_____

Signature_____

Relationship to Child _____

Date_____

Volunteer Opportunities

Please describe any skills, talents, interests, and/or occupation you would like to share with our class if our curriculum coincides with these. Please indicate any area in which you would be willing to contribute your time and/efforts.

Name:_____

Relationship to Child:_____

Child's
Name:_____

Phone Number:_____

Occupation:_____

I would like to help:_____

_____

_____

_____