INFANT CARE AND FEEDING INFORMATION

Child's Name ____________________ Birth Date ____________________

- **This form must be completed, signed and returned prior to your child attending.**
- **This information will change as your child develops. Please keep staff informed of changes by filling out a new information form at least monthly or as changes occur. Forms are available from the teacher or at the front desk.**

FEEDING INFORMATION

Does your child take a bottle? ❍ Yes ❍ No

Can your child feed self? ❍ Yes ❍ No

Is the bottle warmed? ❍ Yes ❍ No

Does your child spit up? ❍ Yes ❍ No

Does your child hold a bottle? ❍ Yes ❍ No

Approximate number of bottles per day. ___________

How is your child burped? ❍ On shoulder ❍ Sitting up ❍ On tummy ❍ Across lap

Does your child eat: ❍ Breast Milk ❍ Whole Milk ❍ Baby Food ❍ Table Foods ❍ Strained Foods
❍ Formula - The only formula to be used is ____________________

Does your child take a pacifier? ❍ Yes ❍ No

When? ____________________ Allergies? ____________________

NAPPING

The American Academy of Pediatrics recommends that healthy, full term infants sleep on their back to reduce the risk of Sudden Infant Death Syndrome (SIDS). This is considered to be primarily important during the first six months or age, when a baby's risk of SIDS is greatest. It does not apply to certain infants with breathing problems or infants with excessive spitting up after feeding. Parents should discuss this policy with their baby's doctor. Any modification to this policy must be obtained in writing from the pediatrician and kept in the child's file at the school.

How do you get your child to sleep? (mark all that apply)
❍ Rock ❍ Lay in bed ❍ Give bottle ❍ Give pacifier ❍ Pat on the back

Does your child suck his/her thumb? ❍ Yes ❍ No

DIAPERING

Use diaper cream (other) for diaper rash? ❍ Yes ❍ No (If yes, you must complete Authorization for Medication)

When your child cries:
❍ Do you walk him/her ❍ Bounce ❍ Give a bottle ❍ Give a pacifier ❍ Pat on the back

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CHILD'S SCHEDULE

	Approximate Time:	Types and Amounts of food:
Breakfast		
Lunch		
Dinner		

	Approximate Time:
Morning Nap	
Afternoon Nap	

Any special likes, dislikes, fears, etc? ❍ Yes ❍ No If Yes, what are they?

Are there any concerns about your child that we should be aware of? ❍ Yes ❍ No If Yes, what are they?

PARENT'S SIGNATURE: ____________________ Date ____________________

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