

Infant Information

Child's Name _____ Date _____

Birthday _____

Hours & Days In Care _____

Does your child take a bottle? Yes _____ No _____

Is the bottle warmed? Yes _____ No _____

Does your child hold her own bottle? Yes _____ No _____

Does your child eat?

Strained Foods _____

Formula _____

Junior Foods _____

Whole Milk _____

Table Foods _____

Other _____

Food Likes _____

Dislikes _____

Allergies? _____

Does your child take a pacifier? Yes _____ No _____

If so, when? _____

Do you use powder when changing your child? Yes _____ No _____

Do you give permission for Desitin or Vaseline to be used for diaper rash? Yes _____ No _____

CHILD'S SCHEDULE

Breakfast- _____

Approx.time

Types and approx. Amount of Food

Lunch- _____

Approx.time

Types and approx. Amount of Food

Dinner- _____

Approx.time

Types and approx. Amount of Food

Morning Nap- _____ Afternoon Nap- _____

Approx.time

Approx.time

Special Comments:
