Dreamer's Child Care Infant Informational Form

Help us get to know your Infant! | Infant Age Group: 6 weeks - 15 months

Child's First and Last Name: _____ Date of Birth: _____

Any Nicknames: _____

Developmental History

Age your child began ***(If not applicable please leave blank)*****:**

Sitting: _____ Crawling: _____ Walking: _____ Talking: _____

Does your child ***(please circle)****:*

Pull Up Crawl Walk with Support Walk Independently

Has your child been enrolled in a care facility in the past? Yes No

If yes, what was the name: _____

How long did the child attend the previous care provider: _____

Family Information

Please list the important adults in your child's life: _____

With whom does the child reside: _____

What is the primary language spoken in the household: _____

Any additional languages: _____

Is the child exposed to books in any additional languages: _____

Does your child interact with siblings or other children in the household:

_____

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Eating Habits

Does your child have a special diet or eating habits:

_____

Is your child eating solids: _____

Describe any eating problems:

_____

Any food allergies:

_____

Foods your child does not eat or refuses:

_____

Does your child use a bottle or pacifier: _____

Does your child use (circle which applies): Spoon Hands Both

Any Formula/Breast Milk: _____

What is your infant's usual eating schedule:

Morning:_____ Afternoon:_____

Evening: _____

***Please also complete 'Dietary Instruction Form' for more specific eating instructions**

Health and Development

What communicable diseases has your child had (Pneumonia, chicken pox, ear infections and etcetera):

_____

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Any serious illness or hospitalization: _____

Any physical disabilities: _____

Any known Allergies: ***(if yes, please provide us with an Individual Allergy Action Plan)***

_____

Is there any medication given regularly:***(if yes, please complete attached Medication Information and Authorization Form)***

_____

What times does your child get fussy: _____

How does your child like to be comforted when upset: _____

What toys does your child prefer the most: _____

Does your child have a specific item (toy, blanket, pillow, etc.) that they need to sleep with? If yes, what is the item's name: _____

What is your infant's usual napping schedule:

Morning:_____ Afternoon:_____

Evening: _____

Toilet/Diapering

Have you begun toilet training your child: _____

If yes, any tips as we continue the training at school: _____

Does your child frequently have a diaper rash: _____

Any words your child uses for urination/bowel movement:

_____

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What are your expectations for your child at Dreamers?

_____

_____

What are your expectations for us?

_____

_____

Parent Name _____

Parent Signature _____

Date _____