

**INFANT CHILD DATA INFORMATION**

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| --- | --- | --- |
| Child’s Name: | D.O.B:   /  / | Today’s Date:   /  / |

**Sleeping Behavior**

|  |  |  |  |
| --- | --- | --- | --- |
| Does your child sleep well? |  | Explain: | |
| Any history of colic? | | | |
| Does your child usually nap: |  | Explain: (please include typical times and duration of naps) | |
| Do you have any concerns about your child’s sleeping habits? |  | Explain: | |
| What does the child take to bed (blanket, pillow, toy, etc….) | | | |
| Describe how your child is typically put down for a nap\bedtime: | | | |
| Does your child typically sleep alone? (Explain) | | | |
| Child typically sleeps in: | Crib | Bed | Other: |

**Developmental History**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Were there any pregnancy or birth difficulties with this child? If yes, please describe | | | | |
| At what age did your child: | Sit Up | Crawl | Walk Unsupported | Talk in short phrases |
|  |  |  |  |
| Do you have any concerns with your child’s development: | | | | |
| Did\Does your child receive support services (OT, PT, Speech\language). If so please describe. | | | | |

**Miscellaneous Information**

|  |  |  |
| --- | --- | --- |
| Has your child had any previous school or play group experience? | | |
| How do you anticipate your child will adjust to this child care program? | | |
| Does your child have an “unsettled” time? (If so what do you do?) | | |
| Do you do anything for teething? | | |
| How does your child relate to strangers? | | |
| Please describe any particular habits, fears, or mannerisms your child displays. | | |
| Does your child have words\nicknames for things and\or caregivers we might not be able to understand or figure out? | | |
| **What are your Child’s Favorite…..** | | |
| Toys | Books | People |
|  |  |  |
|  |  |  |
|  |  |  |

**Toilet Habits**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Is diaper rash a problem? (If so how do you treat it?) | | | | |
| Do you use: (check any that apply) | Diaper Cream | Powder | Special Wipes | Other: |
| Is diarrhea or constipation a problem? (If so how do you treat it) | | | | |
| Do you have any concerns about your child’s toileting habits? If yes please describe: | | | | |

**Family Information**

|  |
| --- |
| Who does your child live with? (Please include people in the household, living arrangements and custody agreements. If the child alternates between households, please explain) |
| Have there been any difficulties or crises in your family such as divorce, death, legal issues or medical problems that may have emotionally affected your child? If yes, please describe: |

|  |
| --- |
| Please include any other information you would like us to know about your child: |

**Approximate Drop off \Pick up times & Person**

(We do understand that this can change, but having estimated times will help us to plan our day and will be helpful in assigning your child’s primary caregivers)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Drop Off | | Pick Up | |
|  | Time | Person | Time | Person |
| Monday |  |  |  |  |
| Tuesday |  |  |  |  |
| Wednesday |  |  |  |  |
| Thursday |  |  |  |  |
| Friday |  |  |  |  |

**Tell us about your child’s day**

Please provide as much information as you feel necessary.

7:30 am my child is…

|  |
| --- |
|  |

8:30 am

|  |
| --- |
|  |

9:30 am

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|  |

10:30 am

|  |
| --- |
|  |

12:30 pm

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|  |

1:30 pm

|  |
| --- |
|  |

2:30 pm

|  |
| --- |
|  |

3:30 pm

|  |
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4:30 pm

|  |
| --- |
|  |

5:30 pm

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| --- |
|  |

Additional Information

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|  |

**Infant Menu Planning**

|  |  |  |
| --- | --- | --- |
| Child’s Name: | Age: | Today’s Date:   /  / |

**Eating Behavior**

|  |  |  |  |
| --- | --- | --- | --- |
| Feeding Schedule\ Frequency\ Amount: | | | |
| How is the child fed (Check any that apply) | | | |
| Lap | Infant Seat | Other: | |
| Bottle Fed | Child Holds Bottle | Caregiver Holds Bottle | Other: |
| Cup with lid | Cup | Child Holds Cup | Caregiver Holds Cup |
| Breastfed | Bottle with breastmilk |  |  |
| Under the guidelines of CACFP, CCCC provides milk based and soy based formula. Will you be providing formula or using what the center provides? | | | |

**Birth – 4 Months**

|  |  |  |
| --- | --- | --- |
| Breast Milk: | Approximate Ounces: | How Often: |
| Formula (Brand): | Approximate Ounces: | How Often: |

**4-7 Months**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Breast Milk: | | Approximate Ounces: | | | How Often: | | | | |
| Formula (Brand): | | Approximate Ounces: | | | How Often: | | | | |
| **Cereal:** | Rice | Oatmeal | | Wheat | Barley | | Mixed (no fruit) | | |
| Number of Tablespoons per feeding: | | | | How Often: | | | | | |
| **Jarred Baby Food** | Applesauce | | Bananas | Pears | Peaches | | | Pineapple | |
| Strawberry | | Blueberry | Apricot | Carrots | | | Squash | |
| Sweet Potatoes | | Peas | Green Beans | Other: | | | | |
| Number of Tablespoons per feeding: | | | | How Often: | | | | | |
| **Pureed Foods** | Chunked Fruit | | Diced Fruit | Chunked Veggie | | Diced Veggie | | | Other: |

**-over-**

**Infant Menu Planning continued**

**8-11 Months**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Fruit** | Apples | Bananas | Mandarin Oranges | Grapes | Strawberries |
| Watermelon | Cantaloupe | Honeydew | Pineapple | Peaches |
| **Cooked Vegetables** | Carrots | Green Beans | Peas | Corn | Mixed Veggie |
| Broccoli | Lima Beans | Cauliflower | Other: | |

**Other Foods**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Mashed Pinto Beans | Animal Crackers | Wheat Pita Bread | Graham Crackers | Cheese | Teething Biscuit |
| Egg Yolks | Cottage Cheese | Saltines | Matzo Crackers | Arrowroot Cookies | English Muffins |
| Soft Tortillas | Tuna Fish | Meatloaf (pureed, or diced) | Meatballs (pureed or diced) | Sloppy Joes | Ground Turkey (pureed or diced) |
| Cooked Chicken (pureed or diced) | Pasta (pureed or diced) | Tortellini \Ravioli (pureed or diced) | Chicken with Rice (pureed or diced) | Pizza | Bagels |
| Waffles | Pancakes | Wheat Bread | Snack Mix | Cheerios | Kix Cereal |
| Please list any other foods your child eats at home that is not listed here: | | | | | |
| Describe a typical meal time: | | | | | |
| List any food allergies, skin allergies or special dietary needs: | | | | | |

**While this list is quite extensive, it does not include everything. Please make sure you receive your copy of the monthly menu and circle all foods on the menu that your child has tried at home, has not had a reaction to, and is ok to eat at day care. Please turn your menu in to your teacher each month.**