EARLY LEARNING CENTERS

INFANT INFORMATION SHEET

Please note: this form must be updated on a monthly basis as changes occur.

Child's Name ___________________________________ **Birth date** _____/_____/_____

Drinking Habits: (please circle which apply): Breast Fed Bottle Fed Cup Milk Formula Juice

How many ounces & what kind or brand of:
Formula:______________& _____oz. Milk:_______________& _____oz. Juice:_______________& _____oz.

Feeding Times: ____

Any problems during feeding? ___________ Please explain____

Eating Habits: What foods has your child been introduced to?

Baby Foods		***Fresh Foods***	
Cereals	_______________________________	Cereals	______________________________
Fruits	_______________________________	Fruits	______________________________
Meats	_______________________________	Meats	______________________________
Vegetables	_______________________________	Vegetables	______________________________
Other	_______________________________	Other	_______________________________

Any diagnosed food allergies? _________ If yes, please provide details: _______________________________________

Any sensitivity or food preferences? If yes, please provide details: ____

Sleeping Habits: (All children must sleep on their backs until they are able to turn over on their own)

A.M. Nap Time__________________ P.M. Nap Time_________________

Any sleeping problems? ___________ If yes, please provide details____

How does your child go to sleep?
____

General Information: Expected arrival time_____________ Expected pick up time____________

Does your child use a pacifier? ___________ If so, when? ____

Any medical problems or conditions we should be aware of? _____ If yes, please explain____________________________

____

Special Instructions or Other Important Information: ____

____

Signature of Parent ____ Date _____________________