

**Infant Information Form**

Baby's Name: \_\_\_\_\_ Enrollment Date: \_\_\_\_\_ Days: M T W T H F

Date of Birth: \_\_\_\_\_ Birth Weight: \_\_\_\_\_ Usual Arrival Time: \_\_\_\_\_ Departure: \_\_\_\_\_

**Please Bring: (Label Everything)**

1. Disposable Diapers    2. Plastic Bottles (please bring 4 sterilized daily)    3. Extra Clothing (2 complete sets)  
4. Baby Food, Unopened if not utilizing center provided    5. Wipes for Diaper Change

**Solid Foods:** Is your baby eating solid foods?     Yes     No    If yes, indicate amount of serving: \_\_\_\_\_  
(If yes, check all that apply)     Table Food     Strained Food     Cereal with Milk

**Liquids:** (Check all that apply)

Cup     Bottle (  Heated-room temp.     Cooled)     Formula     Whole Milk (must be 12 months or older)     Juice    If you checked bottle, is bottle desire:  Before     During     After eating?

**Diapering:** What do you use? (Specify brand names) How often? \_\_\_\_\_ (Every diaper change, once a day, etc.)  
Per state law usage of ointments and lotions will require an additional form be completed.

**Medical:** By law we cannot administer any medication, special diets or vitamins without written, signed and dated instructions from a licensed physician.

Is your baby colicky?     Yes     No    Allergies?     Yes     No (If yes, please list \_\_\_\_\_)

Is your baby on any medication?     Yes     No (If yes, please list \_\_\_\_\_)

Sleep: What is your usual routine for putting your baby to sleep?     Rock     Pat     Pacifier     Bottle     Other \_\_\_\_\_

When does your baby usually sleep and how long? \_\_\_\_\_

Any special sleeping needs? (Blanket, etc.) \_\_\_\_\_ Does your child like to be rocked?  Yes     No

All children are put to sleep on their backs (unless a sleep waiver is signed by parents). This greatly reduces the risk of SIDS (Sudden Infant Death Syndrome).

**\*Activities:** On a nice day can your baby be outdoors?     Yes     No

Can your baby be placed in:     Bouncer     Swing    Activity Center

\*Please note: children will not remain in any of these for longer than 10 minutes at a time.

**Misc.** What calms your infant? (Favorite song, toy, being held, etc.) Please list: \_\_\_\_\_

**Daily Schedule:** Please give us an idea of your baby's schedule between the hours of 6:00 a.m. and 6:00 p.m.

(Please use the back of this sheet of paper if needed)

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Special Instructions: \_\_\_\_\_

(Please use the back of this sheet of paper if needed)

Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_