



Growing Room
CHILD DEVELOPMENT CENTERS
INFANT INFORMATION FORM

CHILD'S NAME _____ DATE _____
BIRTHDAY _____

IS CHILD BREAST-FED? YES _____ NO _____
DOES THE CHILD TAKE A BOTTLE? YES _____ NO _____
IS THE BOTTLE WARMED? YES _____ NO _____
DOES THE CHILD HOLD OWN BOTTLE? YES _____ NO _____
CAN THE CHILD FEED SELF? YES _____ NO _____

DOES THE CHILD EAT:
BABY CEREAL _____ FORMULA _____
STRAINED FOODS _____ WHOLE MILK _____
BABY FOODS _____ OTHER _____
TABLE FOOD _____

DOES THE CHILD TAKE A PACIFIER? YES _____ NO _____
WHEN? _____

HOW DOES CHILD SLEEP (STOMACH/BACK/SIDE)? _____

DOES CHILD NEED SPECIAL BLANKET, STUFFED ANIMAL, ETC. TO SLEEP? YES _____ NO _____
WHAT? _____

FOOD LIKES _____ DISLIKES _____
ALLERGIES? _____

SPECIAL DIAPERING INFORMATION: _____
WHAT DO YOU USE FOR DIAPER RASH? _____

CHILD'S SCHEDULE

BREAKFAST	_____	_____
	(APPROXIMATE TIME)	TYPES AND APPROPRIATE AMOUNTS OF
FOOD		
LUNCH	_____	_____
	(APPROXIMATE TIME)	TYPES AND APPROPRIATE AMOUNTS OF
FOOD		
DINNER	_____	_____
	(APPROXIMATE TIME)	TYPES AND APPROPRIATE AMOUNTS OF
FOOD		
MORNING NAP	_____	AFTERNOON NAP _____
	(APPROXIMATE TIME)	(APPROXIMATE TIME)

SPECIAL INSTRUCTIONS:

GR FORM 47

PARENT'S SIGNATURE