

Infant Daily Care Information Sheet

Child's Name: _____ Date of Birth: _____

Diapering/Toileting

Is your child prone to diaper rash? () Yes () No

Have you supplied diaper rash Cream* for your child? () Yes () No

Please list any specific instructions the teacher needs to know about when/how to use your child's diaper Cream:

Please list any dietary or other concerns that would cause your child's stools to abnormal even when he/she is in good health:

Diet and Eating Habits

Is your child on breast MILK or FORMULA? () Yes () No

If yes, please list what quantity and what schedule your child is on for feeding he/she will be having at the Center:

Is your child on INFANT CEREAL or PUREED SOLIDS (Baby Jar Food)*? () Yes () No

If yes, please list what kind, what quantity and what schedule your child is on for meals he/she will be having at the Center:

Please list any additional information your child's teacher might need to know about your child's eating habits or diet/meal schedule:

IMPORTANT—Please list any food allergies (you will also need to fill out a special diet statement):

Comfort Techniques

What techniques do you find are most effective for calming your child when he/she is upset (rocking, singing a special song, etc.)?

General Communication

Does your child have special words or gestures to communicate things that the teacher might not readily understand? If so, explain:

Does your child use a pacifier or suck his/her thumb? () Yes () No

Sleeping Habits

Does your child sleep with anything special? _____

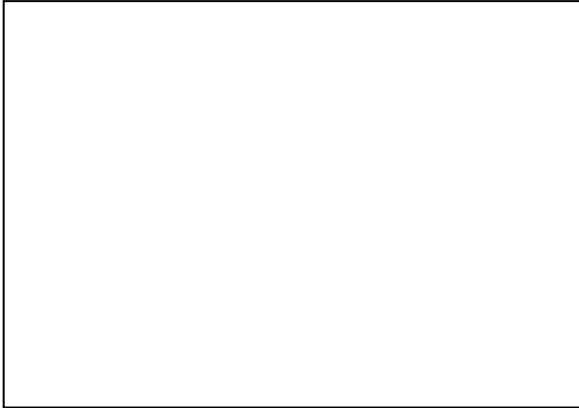
Does he/she usually take a nap? () Yes () No

When and for how long? _____

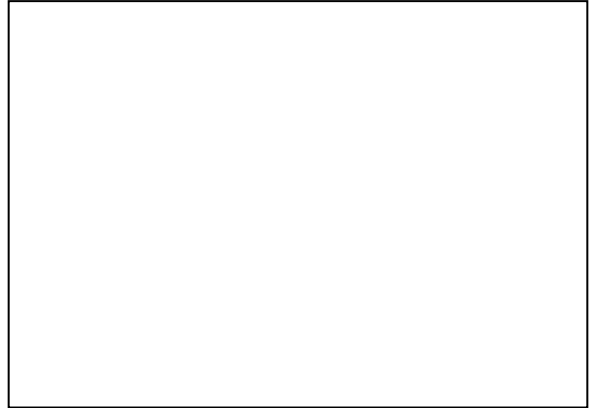
Additional Comments for Care:

Feeding Schedule

Morning—

A large, empty rectangular box with a thin black border, intended for recording the feeding schedule for the morning.

Afternoon—

A large, empty rectangular box with a thin black border, intended for recording the feeding schedule for the afternoon.