Sabes JCC Early Childhood Center

2008-09 Infant Classroom Intake

_____ _____ _____

Child's Name Birthdate Gender

Health

Does your child seem well most of the time? Yes No

Is your child taking any type of medication at this time (including vitamins, laxatives, etc.)? Yes No

If yes, please describe medication and purpose _____

_____

Has your child had an ear infection? Yes No If yes, how many in the last three months? _____

Has your child ever had a cold or throat infections with a fever? Yes No

Has anyone expressed concern about your child's hearing? Yes No

Has anyone expressed concern about your child's vision? Yes No

Has your child ever been seen by a medical specialist? Yes No

If yes, who and for what?_____

_____

What arrangements do you have should your child become ill while at the ECC? _____

_____

Does your child have any special needs? Yes No If yes, please describe _____

_____

Does your child have any other illnesses or diseases Yes No If yes, please describe _____

_____

Has your child ever been hospitalized? Yes No If yes, please describe _____

_____

Does your child have any allergies (eczema, hives, wheezing, food issues, asthma, insect reactions, etc.)?

Yes No If yes, please describe _____

_____

Has your child had any of the following: premature birth, difficulty or Injury in birth, head Injury, or seizures? Yes No If yes, please describe _____

_____

Developmental History

How do you comfort your child? _____

What are your child's favorite toys? _____

What are your child's favorite activities? _____

What language(s) is/are spoken at home? _____

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Continue on other side →

Sabes JCC Early Childhood Center
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Infant Classroom Intake (cont'd)

Sleeping

Please describe above how your child typically falls asleep _____

_____

Does your child typically cry when falling asleep? Yes No
What is your child's present sleeping pattern?
Nighttime:_____ Mornings:_____ Afternoons:_____
Does your child use a pacifier? Yes No
Does your child use a blanket? Yes No
Does your child use a special lovey? Yes No

Feeding

Is your baby breast fed? Yes No
Has your baby had success drinking from a bottle? Yes No
What type of bottle do you use? _____ What kind of nipple? _____
Does your child drink formula? _____ What kind? _____
How often does your baby need to burp?_____

Please share your baby's eating schedule including typical amounts:

	Milk/Formula	Food	Other Liquids
Breakfast			
Lunch			
Snack			

Does your child have any difficulty feeding? Yes No If so, please describe _____

_____

Diapering

How frequently does your baby have a bowel movement? _____
What is the normal appearance? _____
Does your child have a history of diaper rash? Yes No If so, how do you treat it? _____

What are your expectations for your baby in our program?

_____

_____

Is there any thing else you would like the Infant staff to know about your baby?

_____

_____