Infant Information Sheet

Child's Name: _____ Date: _____ Birth Date: _____

Does your child's diet consist of: Please circle

Breast Milk	Yes	No	Strained Foods	Yes	No
Whole Milk	Yes	No	Baby Foods	Yes	No
Formula	Yes	No	Table Foods	Yes	No
Water	Yes	No	Juice	Yes	No

Typical Feeding Schedule:

Approx. Time	Type & Approx. Amounts of Food	Approx. Time	Type & Approx. Amounts of Food

What type of Formula used: _____
Food Likes: _____
Food Dislikes: _____
Does Child feed self? Yes No Does child take pacifier? Yes No
At what temperature does your child take their bottle? Warm Room Temp Cold

Typical Sleeping/Nap Schedule:

Approx. Time	Approx. Duration	Approx. Time	Approx. Duration

How does your child fall asleep?
With Bottle Rocking Puts Self to sleep Other _____

Allergies: _____

I understand it is my responsibility to keep **Kids 'R' Kids #** IL1 updated, in writing, as my child's needs change.

If any creams, ointments, or lotions are needed, a medication authorization form from the front desk will be necessary.

Regarding infant sleeping practices, Kids 'R' Kids follows the recommendations of the SIDS Alliance & American Academy of Pediatrics.

_____ _____

Parent's Signature **Date**