Infant Information

Date: ______________________

Child's Name: ______________________________________ DOB: ________

Pre-Mature Delivery / Full-Term

Child's Birth Weight ______________ Breast Fed / Bottle Fed

Does Child take 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:
Strained Foods [ ] Formula [ ]
Baby Foods [ ] Whole Milk [ ]
Table Foods [ ] Other ____________________________

Does the child take a pacifier? [ ] Yes [ ] No

When? ____

Does Child need special blanket, stuffed animal, etc. to sleep? [ ] Yes [ ] No

What____

Food Likes: ____
Dislikes: ____

Allergies: ____

Child's Schedule:(list approximate times, amounts and types of foods and times and length's of naps)
Breakfast
____
Lunch:
____
Snack: ____

Morning Nap ___________________ Afternoon Nap ________________

Special Instructions:
____
____

Mother's Signature _______________________________ Date __________

Father's Signature ________________________________ Date __________