INFANT INFORMATION SHEET & SCHEDULE

Child's Name ____ DOB: _____/_____/_____
Approx. Time of: Drop Off: __________ Pick Up: __________ Days Attending: M T W R F
Group Enrolled: ☐ Infant One ☐ Infant Two ☐ Waddlers

Child's Ethnic Background: ___African American ___Arabic ___Asian/Pacific Islander
___Hispanic ___American Indian ___White ___Bi-racial _____________________
___Other: ___________________________

What is your cultural heritage? ____
How does your heritage influence your family's traditions, routines and celebrations?
____
____

What language(s) is spoken in the home? ____
___mostly or only English ___some English ___another language and English equally
___no English ___other language(s): ____

Parent/Guardian Names ____________________________ __________________________________
Child Lives With: ___Own Father ___Step Father ___Other ______________________
___Own Mother ___Step Mother
Parents are: ___Married ___Single ___Divorced ___Separated
Is there any custody information Generations should be aware of?
____

Has your child ever been in group care before? ☐ Yes ☐ No
If yes, describe ____

Has your child been identified as having special needs? Yes ___ No___
If yes, by whom? ____

Do you feel your child has special needs? Yes ___ No___
Please describe? ____
Does your child have an active Individual Family Service Plan (IFSP)? Yes ___ No ___
List any special services your child has received since birth: _____________________________________
____
____

Describe what you have noticed about the infant's personality so far? ______________________________
____
____

What are your hopes for your child at Generations Child Care? _________________________________
____
____

Does your child have allergies? ☐ Yes ☐ No If yes, describe: ______________________

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Is your child on medication? ☐ Yes ☐ No If yes, describe: ________________________________
(Please note: By law, Generations cannot administer any medication without written permission from a doctor. Please get forms from the center's office)

Feeding Routine

Check all that Apply: ☐ Breast ☐ Bottles ☐ Sippy Cup
Check all that Apply: ☐ Breast Milk ☐ Formula ☐ Whole Milk ☐ Other _____________ (must be accompanied by a doctor's note)
How often does baby feed? ____
Approx. No. of ounces per fluid feeding: _______________
Baby's preferences (warm, cold, how held)? ____
Burping habits? ____
Mixing instructions for formula fed babies: ____
____

(If you have special requests regarding last feeding of the day, please let us know)

Complete information for meals your infant will receive at Generations:
Baby eats (check all that apply): ☐ Infant Cereal ☐ Infant Food ☐ Finger Foods ☐ Table Food
Time breakfast is usually eaten? ____________ Lunch? ___________ Snack? _____________
What is usually served to baby for each meal?
Breakfast ____
Lunch ____
Snack ____
Food preferences (consistency, temperature, anything they shouldn't have)? ____________________
____

Sleeping Routine & Agreement

What time does baby normally rise in the morning? ____
How often does baby usually nap? ______________ Naps usually last how long? _________________
How does baby usually fall asleep (back, side, with a comfort item, pacifier, etc., **Please note**: Putting infants to sleep on their stomach is unsafe and is prohibited by regulations.) ___________________
____
What else should we know about your baby's nap routine? ___________________________________
____
What soothes baby (blanket, special toy, pacifier, rocking, being held, etc.) _____________________
____

For infants 12-18 months:
_____ I agree that my child can sleep on a cot during nap time between 12 & 18 months of age.
_____ I would rather my child (12-18 months of age) sleep in a crib.
Diapers are changed every two hours, more frequently if needed. Specify special requests:
____

Parent Signature: ____ Date: _______________