

# Infant/Toddler Information Sheet



Infant/Toddler's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

## Feeding Instructions

How is He/She Fed?	<input type="checkbox"/> Breast	<input type="checkbox"/> Bottle	<input type="checkbox"/> Both
Warm Bottle	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Burp Instructions: _____ _____ _____ Special Instructions: _____ _____ _____
Warm Food	<input type="checkbox"/>	<input type="checkbox"/>	
Self-Feeder	<input type="checkbox"/>	<input type="checkbox"/>	
Spoon	<input type="checkbox"/>	<input type="checkbox"/>	
Formula	<input type="checkbox"/>	<input type="checkbox"/>	
Whole Milk	<input type="checkbox"/>	<input type="checkbox"/>	

Times of Feedings		Kinds of Food (jars, bottles, solids)	Amounts	Amounts Eaten
_____		_____	_____	_____
_____		_____	_____	_____
_____		_____	_____	_____
_____		_____	_____	_____

Diapering Report	Sleep Record												
What lotion, ointment or powder would you like us to use when: (please provide)  Wet: _____ Bowel Movement: _____ Rash: _____	How are they put to sleep?  <table> <tr> <td><input type="checkbox"/> Pat</td> <td><input type="checkbox"/> Back</td> </tr> <tr> <td><input type="checkbox"/> Rock</td> <td><input type="checkbox"/> Tummy*</td> </tr> <tr> <td><input type="checkbox"/> Music</td> <td><input type="checkbox"/> Side</td> </tr> <tr> <td><input type="checkbox"/> Pacifier</td> <td></td> </tr> </table>	<input type="checkbox"/> Pat	<input type="checkbox"/> Back	<input type="checkbox"/> Rock	<input type="checkbox"/> Tummy*	<input type="checkbox"/> Music	<input type="checkbox"/> Side	<input type="checkbox"/> Pacifier					
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<u>Miscellaneous Information</u> Allergies: _____ Does your child use a pacifier? _____ Other: _____ _____ _____	<table> <tr> <td>What Times?</td> <td></td> <td>How Long?</td> </tr> <tr> <td>_____</td> <td></td> <td>_____</td> </tr> <tr> <td>_____</td> <td></td> <td>_____</td> </tr> <tr> <td>_____</td> <td></td> <td>_____</td> </tr> </table> Special Needs _____ _____	What Times?		How Long?	_____		_____	_____		_____	_____		_____
What Times?		How Long?											
_____		_____											
_____		_____											
_____		_____											

Note: New information to be updated as needed or filled out every 2 months. Please mark your child's name on all supplies (diapering supplies) and all bottles.

\_\_\_\_\_  
Parent/Guardian's Signature

\_\_\_\_\_  
Date

\*Infants must have a WAIVER STATEMENT ON INFANT SLEEP POSITION attached to this sheet to sleep on their tummies. See Infant Sleep Policy.