



Infant Information Sheet

Child's Name: _____ Date: _____
Birthday: _____

	Yes	No	Does your child eat:	
Does child take bottle:	<input type="radio"/>	<input type="radio"/>	Strained Foods	<input type="radio"/>
Is the bottle warmed?	<input type="radio"/>	<input type="radio"/>	Baby Food	<input type="radio"/>
Does the child hold own bottle?	<input type="radio"/>	<input type="radio"/>	Formula	<input type="radio"/>
Can the child feed self?	<input type="radio"/>	<input type="radio"/>	Whole Milk	<input type="radio"/>
Does your child take a pacifier?	<input type="radio"/>	<input type="radio"/>	Table Foods	<input type="radio"/>
			Other	<input type="radio"/>

Child likes to sleep on its: Side Stomach Back
Does your child need a special blanket, stuffed animal, etc. to sleep? Yes No What? _____

What type of formula used? _____
Amount of formula to be given: _____ Date: _____
Updated amounts of formula: _____ Date: _____
_____ Date: _____
_____ Date: _____

Food likes: _____ Food dislikes: _____

Allergies (including any premixed formula)? _____

Do you use powder when changing your child? Yes No

Instructions for introducing foods: _____

I understand it is my responsibility to keep StarChild Academy child care center updated as my child's needs

Child's Schedule	Time Available	Approx. Time	Types and Approximate Amounts of Food
Breakfast	6:00 - 8:30		
Morning Snack	9:00 - 10:00		
Lunch	10:45 - 12:45		
Afternoon Snack	2:00 - 3:00		

change. Please update every 30 days.

Parent's Signature