

Child's Name: _____

Children's Individual Schedules – Infant

Feeding:

Does your child have any feeding problems or difficulties? Yes ___ No ___ (If Yes, please explain)

What type of food does your child have?

(a) Formula _____ Amount _____ Frequency _____

(b) Cereal _____ Amount _____ Frequency _____

(c) Strained Foods _____ Amount _____ Frequency _____

(d) Water/Juice _____ Amount _____ Frequency _____

(e) Regular food _____

Is your child breast fed?

If you plan to continue, how can the centre help you transition?

3. Please provide a daily feeding schedule

Time	Type of Food	Amount
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

4. Does your child have any allergies or foods he/she is unable to keep down? Yes ___ No ___
(If Yes, please explain)

What do you use as a substitution?

What are your child's favourite foods so far?

Sleeping:

How long does your child typically sleep at night ?

What are his/her sleeping patterns during the day

AM: _____

PM: _____

Does your child have a special bedtime routine/special way of helping him/her go to sleep?

Does your child take a pacifier, bottle, special toy or blanket to bed?

What kind of signals does your child give when sleepy?

Does your child cry when he/she wakes up?

Does your child prefer to sleep on his/her stomach, back or side?

Does your child sleep consistently in a crib at home ?

On occasion, the babies fall asleep in the rock-a-roos/car seat.

_____ If my child falls asleep in the rock-a-roos/car seat, I would like him/her moved to a crib

_____ If my child falls asleep in the rock-a-roos/car seat, he/she can stay there to sleep

_____ If my child does not sleep in a crib at home, there, maybe an adjustment period when he/she starts at the centre. Until my child becomes familiar with the crib, (during the initial adjustment period) he/she may sleep in a rock-a-roos/car seat.

Parent's Signature

Date

Toileting:

For diaper change, do you prefer?

Ointment _____ Vaseline _____ Powder _____

Special Instructions (eg: each change, when red, etc.)

Does your child have a diaper rash often? Yes___ No ___

What seems to cause it?

How do you treat it?

What type of diapers do you use? Disposable _____ Organic _____ Cloth _____

Does your child have a regular bowel movement? Please state times.

Does your child signal when having a bowel movement?

General Information:

Are there any special games, rhymes, songs or physical activities, etc. that your child particularly enjoys?

Is there any other information about your child that you can share that will benefit his/her stay at the centre?

Parent's Signature

Date

*** This is to be updated every 2 months**

Revised on: _____

In the last two months, is there any new information that can be provided, if no pout NA and sign:

Parent's Signature

Date

Revised on: _____

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