Busy Buddies Babies

Infant Care Information

Child's Name: ________________________ **Birthdate:**________________

*Please fill out a new form as changes occur.

Feeding Information

Does your child take a bottle? Yes No

Is the bottle warmed? Yes No

Does your child hold a bottle? Yes No

How is your child burped? On Shoulder Sitting Up On Tummy Across Lap

Does your child eat: Breast Milk Whole Milk Baby Food Formula

Strained Foods Table Foods Other________

Food Allergies:____

Foods you wish to avoid at this time: ____

Has your child been introduced to: Eggs Berries Fish Chocolate

Napping Information

How do you get your child to sleep? Rock Lay them down in bed Give bottle Give pacifier Pat on back Other:______________

Does your child suck his/her thumb/fingers? Yes No

Does your child have a pacifier? Yes No

When your child cries do you: Bounce Give bottle Give pacifier Pat on back Walk them Other:______________

Child's Sample Schedule at this time

	Approx. Time	Types and Amounts
Breakfast		
Lunch		
Snacks		

	Approx. Time	Types and Amounts
Bottles		

Morning Nap Approx. Time:____

Afternoon Nap Approx. Time:____

What does your child enjoy doing during awake times:__________________________________

Any special likes, dislikes, fears, etc?____

Are there any concerns about your child that a provider should be aware of?____

Please comment on any other information you may feel would be helpful in getting to know/caring for your child:____
____
____
____
____
____
____
____
____
____

Parent's Signature_________________________________ **Date:___________________**