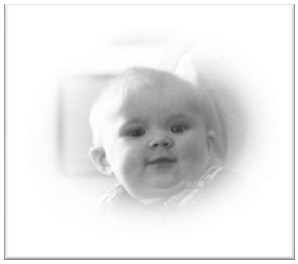

Ladybug Child Care Center
Getting to Know Your Infant

Child's Full Name: _____
Child called: _____ Date: _____

Child Lives With:
Name: _____ Relationship to child: _____
Name: _____ Relationship to child: _____
Sibling's names & ages: _____

Non-Custodial Parents:
Name: _____ Relationship to child: _____
Does the child see this person? _____Will this person interact with your child at the Center? _____
Any restrictions/limitations (COPY OF LEGAL DOCUMENTS MUST BE FURNISHED):_____

Health

Birthdate: _____Birth Weight: _____ Birth Length: _____ Premature: __Yes __ No
Does your child seem well most of the time? __Yes __No
Is your child taking any medications regularly (such as Tylenol, laxatives, vitamins, etc.) __Yes __No
If yes: what, why & when? _____
How many ear infections has child had in the past year? _____
Has your child ever been seen by a medical specialist? __Yes __ No
If yes, explain: _____
Has your child had any other illnesses/diseases? __ Yes __ No
If yes, explain: _____
Has your child had any serious accidents, hospitalizations, etc.? __Yes __No
If yes, explain: _____
Has your child had any of the following (please explain all that you marked):
_____ Birth injury or defect: _____
_____ Seizures: _____
_____ Breathing problems: _____
_____Head injuries: _____
_____ Allergies, eczema, hives, drug/food intolerances, asthma/wheezing, insect stings:
_____
_____Other: _____

Developmental History:

Has child been away from you before: __Yes __No How frequently? _____
Has child been in a group before? __Yes __ No If yes, explain: _____
How does child handle separation from parent? __Without upset __ briefly/mildly upset
Is your child easily frightened? __Yes __No If yes, explain: _____
How do you comfort your child? _____
Emotional Behavior (please indicate all that apply):
__Happy __Calm __Active __Whining __Excitable __Cheerful __Stubborn __Crying
__Cooperative __Quiet __Independent __Wants Own Way __Temper Tantrums __Easily Angered
What are child's favorite toys & activities? _____

Sleep Patterns:

Describe any special ways of helping your child go to sleep?

_____

Does your baby cry when going to sleep? __Yes __No If yes, for how long? _____

What is your baby's present sleep pattern?

Night: from_____ to_____ from_____ to_____

AM Nap: from_____ to_____ from_____ to_____

PM Nap: from_____ to_____ from_____ to_____

At sleep times does baby need: ____pacifier ____special blanket ____ special toy

Other information: _____

Food Patterns:

How long has your baby been on a bottle? _____ _____

What will your baby accept in the bottle? ____Breast milk ____formula ____fruit juice ____water

Does your baby drink from a: __bottle __cup __both

Does your baby hold own: __bottle __cup __both

Has your baby had any feeding problems? __Yes __No If yes, explain: _____

Does your baby eat table foods? __Yes __No If yes, what types: _____

Does your baby feed themself? __Yes __No If yes, what foods: _____

Other information: _____

Toilet Patterns:

How often does your child have a bowel movement? _____

Is your child's average stool:

____ Very soft (like a newborn) ____ soft ____firm (like an adult) ____ very hard (pellet like)

Does your child often have a diaper rash? __Yes __No If yes, how is it treated? _____

Other information: _____

What would you like us to do for your child?

_____

_____

Suggestions to be more effective with your child:

_____

_____

Additional Comments:

_____

_____

_____

Thank you for helping us get to know your child!

Send To Ladybug