Infant Developmental/Health History

Infant's Full Name

Date of Birth Gender: ❒ Male ❒ Female

Health History

Does your infant seem well most of the time? ❒ Yes ❒ No

Is your infant taking any medications now? ❒ Yes ❒ No

If yes, please list and explain for what purpose:

In a year, has your infant had 3 or more ear infections? ❒ Yes ❒ No

In a year, does your infant usually have more than 3 colds or sore throat infections with a fever?

❒ Yes ❒ No

Has your infant been seen by a medical specialist? ❒ Yes ❒ No

If yes, for what reason?

What arrangements have you made for the care of your infant should he/she become ill while in child care?

Does your infant have any health-related or other needs that you would like us to be aware of?
❒ Yes ❒ No

If yes, please list:

Does your infant have any contagious illnesses that could impact other children or staff? ❒ Yes ❒ No

If yes, please provide details:

Has your infant ever been hospitalized? ❒ Yes ❒ No

If yes, please provide details:

Has your infant had any serious accidents or poisonings? ❒ Yes ❒ No

If yes, please provide details:

Does your infant chew unusual things such as pencils, chalk, cribs, window ledges, paint chips, plaster, or hair? ❒ Yes ❒ No

If yes, please provide details:

Is your infant allergic to anything? ❒ Yes ❒ No

If yes, please list and note what symptoms your infant exhibits when having an allergic reaction:

Developmental History

How do you comfort your infant?

What are your infant's favorite toys?

What are your infant's favorite activities?

What language(s) is/are spoken in your home?

Sleeping

Please list any specific ways you help your infant go to sleep

Does your infant cry when going to sleep? ❒ Yes ❒ No

What is your infant's current sleeping schedule?
Nighttime:
Morning nap:
Afternoon nap:
Other (list):

At naptime, does your child use (check all that apply): ❒ pacifier ❒ stuffed animal/toy ❒ blanket

Feeding

Is your infant breast-fed? ❒ Yes ❒ No Formula fed? ❒ Yes ❒ No

If your infant is formula fed, what type of formula do you use?

Type of Formula Amount per serving Times per day

What type of bottle and nipple does your infant prefer?

Does your infant need to be burped? ❒ Yes ❒ No

Does your infant eat solid food? ❒ Yes ❒ No

If yes, amount per serving Times per day

❒ Cereal ❒ Fruit ❒ Meat ❒ Tofu ❒ Cheese ❒ Vegetables

Particular likes or dislikes?

Does your infant eat table food? ❒ Yes ❒ No If yes, what types of food has he/she been fed thus far:	
Does the infant drink water? ❒ Yes ❒ No	Juice? ❒
What is your infant's current eating schedule? (please specify times and amounts) Nighttime: Morning: Afternoon: Snacktime:	
Please list any special feeding concerns we should be aware of:	

Toileting

How frequently does your infant have a bowel movement? Please describe typical appearance of bowel movement:
Does your infant often get a diaper rash? ❒ Yes ❒ No If yes, how do you treat it?