ALL ABOUT KIDS
Childcare and Learning Center

Infant Profile (Room 1)

Child's Name: _____ Date of Birth: _____

Feeding

(Please circle and/or complete questions)

•What are you feeding your infant?
Formula Brand: _____
Breast Milk

•Amount of Feeding: ____oz.

•Frequency of Feeding: every ___ hours

•My infant likes their bottle: Room Temp Warm Very Warm/NOT HOT Cold

•Does your child hold their own bottle? Yes No
•Does your child use a sippy cup? Yes No
•Does your child feed themselves? Yes No

•Is you child eating baby food? Yes No (if **yes** please complete the section below)
Brand: _____
Types: _____
Amount: _____
Frequency: _____

•Is your child eating table food? Yes No

Food Likes: _____
_____

Food Dislikes: _____
_____

Allergies

•Does your child have any allergies? Please include seasonal allergies. _____
_____

•Items or Environments to avoid? _____
_____

Daily Needs

•Does your child use a pacifier? Yes No

•What is your child's sleeping position? _____**

•Does your child have a nap schedule? _____

_____

•Hints for getting baby to sleep? _____

_____

•What activities does your child enjoy? _____

_____

**If an infant is to sleep on anything other than their back, a medical statement must be completed by your physician and signed by the parent.

***Stuffed Animals, comforters, pillows etc. are not allowed in infant's cribs until 12 months of age.**

Family

•What is the marital status of the child's parents? _____

•Please list the names and ages of siblings: _____

_____

•Does anyone besides the immediate family live in the household? _____

_____

•What primary language is spoken in the home? _____

Please list any other important information about your child that would be helpful or you would like staff to know about. _____

_____

_____

_____

_____

_____

Parent Signature: _____ Date: _____

***Please complete the Infant Feeding Schedule attached. The infant feeding schedule needs to be updated whenever there is a change in your child's schedule.**