Government of Saskatchewan

Infant Social Resume

Child's Name: _____

Does your child have a nickname? ☐ Yes ☐ No If Yes, what is it? _____

Family

Names of brothers and sisters (include nicknames)	Birth dates	Does this sibling live in the same home as this child?

Names of others living in the home	Relationship to child

What languages are spoken in your home? _____

Does your child have any pets? ☐ Yes ☐ No If Yes, what are they? _____

Food

Is your child **breast-fed**? ☐ Yes ☐ No

If **Yes**:

Do you plan to continue breast-feeding? ☐ Yes ☐ No

If Yes, how do you plan to carry this out? _____

What is your child's feeding schedule? _____

Do you supplement? ☐ Yes ☐ No If Yes, with what and how often? _____

Is your child **bottle-fed**? ☐ Yes ☐ No

If **Yes**: What is your child's bottle feeding schedule? Please complete chart:

Liquids	Type	Amount	Times
Formula			
Milk			
Water			
Other:			

What position does your child like to be in while bottle-feeding? _____

What position does your child like to be in while being burped? _____

Food continued on next page

Does your child spit-up? Please comment: _____

_____

Has your child been introduced **to solids**? ☐ Yes ☐ No If Yes, what type? ☐ Baby food ☐ Table food

What is your child's feeding schedule? Please complete chart. (Only list foods to which your child has successfully been introduced)

Solids	Type	Consistency	Amount	Times
Cereals				
Cereals				
Cereals				
Vegetables				
Vegetables				
Vegetables				
Vegetables				
Fruits				
Fruits				
Fruits				
Fruits				
Meats				
Meats				
Snacks				
Snacks				

Does your child have any food sensitivities? ☐ Yes ☐ No If Yes, please identify: _____

_____

Describe your child's appetite: _____

_____

What foods does your child like and dislike? _____

_____

Sleep

Describe your child's sleep routine (include times and lengths of naps) _____

_____

_____

Describe ways you help your child go to sleep (include position, special blanket, lighting, sound, etc.)

_____

_____

Does your child usually cry when going to sleep? ☐ Yes ☐ No If Yes, for how long? _____

Does your child usually cry when waking? ☐ Yes ☐ No

Where does your child usually sleep? Please describe: _____

_____

Diapering

What type of diapers does your child use? _____

Describe your child's normal diapering routine (include double-diapering, liners, creams, powders, etc.)

_____

_____

Is your child prone to diaper rash? ☐ Yes ☐ No Treatment used: _____

_____

How many diapers would your child normally use between 8:00 a.m. and 5:00 p.m.? _____

Please comment on your child's bowel movements (including frequency, color, consistency, constipation, etc.)

_____

_____

Social/Emotional Development

Describe your child's temperament: (i.e. colic, likes to cuddle) _____

_____

What signs does your child give of being hungry, tired or over stimulated? (i.e. pulls at ears, rubs eyes) _____

_____

Does your child separate easily from you? ☐ Yes ☐ No Please comment: _____

_____

Is your child afraid of anything? ☐ Yes ☐ No Please describe: _____

_____

Does your child have a favorite toy, blanket, bottle or soother? ☐ Yes ☐ No Please identify: _____

_____

Does your child spend time with other children? ☐ Yes ☐ No Please comment: (who, when, how much)

_____

_____

What activities does your child enjoy? _____

_____

What activities does your child dislike? _____

_____

Provide any further information relating to your child that would be helpful in understanding and caring for your child.

_____

_____

_____

_____

Note: Personal health information may be disclosed by the facility to the Ministry of Education in the course of reviewing the facility's record keeping obligations.

Date: _____ / _____ / _____
Year Month Day

_____
Parent/Guardian Signature