Small World Learning Center

INFANT AND TODDLER INFORMATION

Child Center Small World Learning Center			Date Entered
Name of Child	Nickname	Birthdate	Child's Age at Entry
Name of Parent(s)	Phone 1		Phone 2

Health

Any disabilities or abnormalties? _____

Any daily medication? _____

Any previous medical history? _____

Any allergies? _____

Background

Any special information re: pregnancy, birth, first weeks of life that may be important? _____

_____

Does your child use a pacificer? ❑ Yes ❑ No If yes, during what times of day? _____

Does your child have a blanket / toy, other soothing item? ❑ Yes ❑ No If yes, what? _____

Language

Does he/she have any words? ❑ Yes ❑ No If yes, what do they mean? _____

What languages are spoken in the home? _____

Special words and their meanings _____

Family

Members in Household	Relationship	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Any pets? ❑ Yes ❑ No If yes, names? _____

Play and Comfort

Favorite Characters, Games, Songs and/or Books _____

How do you comfort your baby when s/he is upset? _____

Solid Foods

_____ Table Foods

Amount / Serving _____

_____ Baby Foods

Vegetables

_____ Peas

_____ Carrots

_____ Gr. Beans

_____ Beets

_____ Squash

Fruits

_____ Apricots and Applesauce

_____ Pears

_____ Peaches

_____ Prunes in Tapioca

_____ Plums in Tapioca

Meats

_____ Beef

_____ Veal

_____ Turkey

_____ Liver

_____ Lamb

Schedule _____

_____

_____

Food Allergies _____

_____

_____

Liquids (Amount per serving)

_____ Cup _____ Bottle

Milk: ❑ Whole ❑ 2% ❑ Breastmilk

❑ Formula: Brand_____

❑ Heated ❑ Room Temp ❑ Cool

Juice

_____ Pineapple _____ Grape _____ Apple

_____ Orange _____ Apricot _____ Peach

_____ Grapefruit Other _____

Schedule: _____

Sleep

Any special sleeping needs? _____

_____

Does your baby like to be rocked? ❑ Yes ❑ No

What is your usual routine for putting your baby to bed? _____

_____

_____

When does h/she usual sleep? _____

_____

How long? _____

Is your child on a daily schedule?

If so, please fill out.

7:00 _____

8:00 _____

9:00 _____

10:00 _____

11:00 _____

12:00 _____

1:00 _____

2:00 _____

3:00 _____

4:00 _____

5:00 _____

Diapering

Powder ❑ Yes ❑ No

Desitin ❑ Yes ❑ No

Other Ointment? _____