Infant Room

It is our intention at Little Rascals is to foster a strong reciprocal relationship with the families that we serve. The purpose of the following form is to help us get to know your child and your family better so that we may serve your family better. This form will be kept strictly confidential. Only your child's teacher, the state of Minnesota, and administration will have access to the information contained in this form.

Child's name: _____DOB: _____

Parent's name: _____

Parent's name: _____

Feeding Plan: Liquids

Child is to be fed the following:

□ Breast Milk

□ Formula- Brand _____

□ Milk

- Whole
- 1 % **(Special Diet statement required if under 2)** ○ Other **(Special Diet statement required)**

  Brand: _____

How many ounces per feeding at the time of starting care?

Breast Milk _____

Formula _____

Child now uses:

□ Bottle _____

□ Cup _____ □

Spoon _____

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□ Fork _____

Solid Foods:

Child is currently on solid foods?

- Yes
- No

What age did you begin to introduce solid foods? _____

Can your child feed themself?

- Yes
- No

Approximately what time do you serve:

_____ Breakfast

Lunch_____

_____ Supper

Sleeping Patterns: Sleeping Schedule

Does your child sleep on their:

- Back
- Belly

Does your child use a sleep sack or swaddle?

- Yes
- No

Where does your child sleep at home?

All children sleep in a crib while in care

- Crib
- Pack and Play
- Swing
- Bouncy Chair
- Co-sleep
- Dark Room

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Does your child take a nap in the morning?

- ☐ Yes
- ☐ No

Approximately what time? _____

Usually how long? _____

Does your child take a nap in the afternoon?

- ☐ Yes
- ☐ No

Approximately what time? _____

Usually how long? _____

Does your child sleep with any transitional objects (blankets, pacifier, etc.)?

Infants under 1 year old may only have a pacifier and swaddle/sleep sack in their crib

- ☐ Yes
- ☐ No

If yes, what objects?

_____

Does your child fall asleep easily?

- ☐ Yes
- ☐ No

Does your child have difficulty staying asleep?

- ☐ Yes
- ☐ No

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Diapering and Toilet Training Plan: Diaper/Toilet Training Infants

will be checked every 2 hours and/or changed if soiled.

Child uses:

- ☐ Disposable diapers- Brand _____
- ☐ Cloth Diapers: **Parent must provide diapers, covers, and dirty diaper disposal (cloth diapers will not be washed at our facility)**
- ☐ Wipes- Brand _____

Does your child have highly sensitive skin?

- ☐ Yes
- ☐ No

Does your child get frequent diaper rash?

- ☐ Yes
- ☐ No

Does your child use any lotion, powders, or ointments?

- ☐ Yes ☐
  No
  If yes, please specify type and brand: _____
  _____

(Medication Administration Form Required)

Active play, diapering and toileting and all other interactions will be provided around your child's routine.
How would you describe your child's personality?

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_____

_____

_____

_____

Does your child have a fussy time?

- ☐ Yes
- ☐ No

If yes, please specify time and how it is handled:

_____

_____ _____

_____

Does your child have any fears?

_____

_____ _____

Was your child born full term?

- ☐ Yes
- ☐ No

Is your child able to do any of the following?

- ☐ Sit up alone
- ☐ Pull to standing
- ☐ Crawl

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- Walk along objects such as couches
- Walk without support

Does your child have frequent colds, ear infections, colic, etc.?

Yes
No

If yes, please describe:

_____

_____

_____

Does your child spit up frequently?

Yes
No

Are there any known allergies in the family?

Yes
No

If yes, please explain:

_____

_____

_____

Do you have any concerns about your child's development?

Yes
No

If yes, please explain:

_____

_____

_____

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Are there any developmental concerns in the family such as with a parent or sibling?

☐ Yes ☐
No

If yes, please describe:

_____

_____

_____

_____

Is your child on any daily medications?

☐ Yes ☐
No

If yes, are there any side effects that we should be aware of?

_____

_____

_____

Is this your child's first experience in childcare?

☐ Yes
☐ No

Does your child have any special needs?

☐ Yes
☐ No

If yes, is this special need:

_____Medical

_____ Developmental

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If Medical, has the child been diagnosed by a physician

- ☐ Yes
- ☐ No

If yes, what is the diagnosis:

_____

If Developmental, has the child been evaluated by a professional?

- ☐ Yes
- ☐ No

If yes, what was the result of the evaluation:

_____

_____

_____

_____

What language is spoken at home? _____

Is there anything else that you would like to share with us?

_____

_____

_____

_____

Please share your feelings and expectations regarding your child's care and education.

_____

_____

_____

_____

_____

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This form is required to be updated two times per year as your child's needs change, or if your child transitions to a new room, and reviewed with parent/guardian prior to being signed and approved by persons listed below.

_____

Parent/Guardian's Signature

_____

Date

_____

Teacher's Signature

_____

Date