	Jan.	Feb.	March	April	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.
Initial & date	___	___	___	___	___	___	___	___	___	___	___	___

Health

Does your child have any allergies?	Yes	No
If so, what allergies does your child have?		
How should we respond if he/she has an allergic reaction? * severe allergy problems needing epi pins must be posted for your child's safety*		
Does your child have an existing illness?	Yes	No
Has your child had a previous serious illness or injury, or hospitalization during the past 12 months?	Yes	No
Is your child taking any medication?	Yes	No
If so, how is the medication administered, and will it need to be administered while he/she is in care? *authorization for dispensing medication must be filled out for each illness or prescription*		
Is the medication prescribed for continuous use?	Yes	No
Are there any side effects we should be alerted to?	Yes	No

When your child gets upset, what helps him/her calm down?
What is a good way to distract your child when he/she is having a temper tantrum?
Are there any particular routines that are particularly helpful at naptime?
What position is most comfortable for your child when he/she is napping?

Behavior

Activities:

What activities do you like to do with your child?
What activities does your child like to do when playing with other children?
What does your child like to do when he is playing alone?

Family History:

Tell me about your family (i.e. child's parents, siblings, grandparents, and other extended family)

	Jan.	Feb.	March	April	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.
Initial & date	___	___	___	___	___	___	___	___	___	___	___	___

Infant Profile

Child's Name:_____ **B-day:**_____

Contact Information: (circle number to call first)

Mom (name):_____**(cell)**_____**(wk)**_____

Dad (name):_____**(cell)**_____**(wk)**_____

Home number:_____

<u>Please tell us about your child's</u>:

Personality:_____

_____

_____

Likes and dislikes:_____

_____

_____

Sleep habits/schedule:_____

_____

_____

Circle self-comfort items: blanket, pacifier, other_____

Diapering:
Powder, ointment, diaper creams (parent's please label)

Allergies, dietary needs:
My child is allergic to_____

feed on demand **scheduled feedings** _____, _____, _____, _____

breast milk **formula** **heat** **yes/no**

	temperature	amount	time of day
Cereal			
Jar food			
Table foods			

***All babies are placed on their backs to sleep.**

Parent Signature:_____ **Date:**_____