All About Me (Infants)

Child's Name _____ Birthdate_____

My daily drop off time will be:_____
My daily pick up time will be:_____
My days of week in care will be: (Circle all that apply)
MON TUES WED THURS FRI

Bottle Instuctions: (check all that apply)
I have: Breast Milk_____Formula_____Nursing at home_____
I like it: Cold_____Warm_____Room Temp_____
I like my bottles every: (Circle)
2 hours_____3 hours____4 hours_____
Do not go over_____hours without eating a bottle

Food: (circle yes or no)
I eat baby food: YES NO
I eat table food: YES NO
I eat finger food: YES NO
I may eat the food that is provided by Brite Beginnings when age appropriate: YES NO

Nap Time: (check all that apply)
I like to be: rocked_____Left Alone_____
I sleep on my: back_____Stomach_____Side_____
I like to use a: pacifier_____blanky_____other_____
Do not let me sleep more than _____ hours at a time.
I like to sleep at these times at home: _____.
Anything else you would like us to know about your child
_____
_____.