David's Christian Learning Center
Getting to Know Your Infant

EATING

My infant is Breast Fed: _____

Do you offer supplemental feedings? Yes _____ No _____

If yes, please describe(brand of formula/amount): _____

_____

My infant is Bottle Fed: _____

Describe the brand/kind of formula: _____

Current ounces per feeding: _____

Schedule: Time of Day/Length of Feeding

AM	PM
_____ to _____	_____ to _____
_____ to _____	_____ to _____
_____ to _____	_____ to _____
_____ to _____	_____ to _____

Has your infant started eating solids? Yes _____ No _____

If yes, please describe:

Cereal: _____ Amount: _____ x/day: _____

Fruits: _____ Amount: _____ x/day: _____

Vegetables: _____ Amount: _____ x/day: _____

Meats: _____ Amount: _____ x/day: _____

During a feeding, which do you offer first? Milk _____ Solids _____

Does your infant have any allergies? Yes _____ No _____

If yes, please describe: _____

Is your infant on a modified diet? Yes _____ No _____

If yes, please describe: _____

Does your infant have any feeding problems? (i.e., vomiting, spitting up, etc.)

If yes, please describe: _____

SLEEPING

What is your infant's sleep schedule?

AM		PM	
_____ to	_____	_____ to	_____
_____ to	_____	_____ to	_____
_____ to	_____	_____ to	_____
_____ to	_____	_____ to	_____

Does you have any special ways of helping your infant fall asleep? Yes _____ No _____

If yes, please describe: _____

Does your infant usually cry when going to sleep? Yes _____ No _____

Does your infant use a pacifier at nap times? Yes _____ No _____

Does your infant have difficulties associated to sleep? Yes _____ No _____

If yes, please describe: _____

DIAPERING

How often does your child have a bowel movement? _____

Appearance of stools? _____

Does your child have any difficulties with bowel movements or urination? Yes _____ No _____

If yes, please describe: _____

Which ointment do you use on your infant for diaper rashes?

Desitin _____ A&D _____ Lotrimin _____ Other _____

SOCIAL DEVELOPMENT

Describe your infant's temperament/personality: _____

How does your infant react/relate to other children? _____

How does your infant react/relate to other adults? _____

What activities does your infant enjoy? _____

What is the main language spoken at home? _____ Secondary? _____

EMOTIONAL DEVELOPMENT

How does your child react to separation from parent/guardian? _____

How does your infant express happiness? _____

How does your infant express anger? _____

How does your infant express frustration? _____

Does your infant have any specific fears? _____

HEALTH

List any non-food allergies your infant has: _____

Does your infant require any regular medications? Yes _____ No _____

If yes, please list the medication, dosage and reason why your child takes this medicine:

_____

_____

Has your infant ever been hospitalized? Yes _____ No _____

If yes, please specify when and why: _____

_____

Has your infant ever experienced any serious accidents or poisoning? Yes _____ No _____

If yes, please describe: _____

Does your infant have any handicaps or special needs? Yes _____ No _____

If yes, please describe: _____

Does your infant have a chronic illness/disease (i.e., Diabetes, Epilepsy, Cystic Fibrosis?)

Yes _____ No _____

If yes, please describe: _____

Has your child ever been evaluated by a medical specialist? Yes _____ No _____

If yes, please describe: _____

Is there any other medical information that David's Christian Learning Center staff should be aware of?

Yes _____ No _____

If yes, please describe: _____

_____ _____

Parent/Guardian signature **Date**