Little Village Home Child Care LLC

Infant History

Today's Date _____

Child's Full Name _____

Date of Birth _____

Gender: M F

Health

1. Is your child currently taking any medications? Yes No If yes,

Name of Medication: _____

Reason for Medication: _____

2. Does your child have any special needs or disabilities? Yes No If yes, please describe:

_____

_____

3. Has your child had any of the following? (Please Circle.)

Premature birth Trouble breathing at birth

Birth injury/Defect Head Injury Convulsions/Seizures

Allergies (including eczema, hives, drug, food intolerance, hay fever, wheezing, asthma, insect stings)

_____

_____

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Development

4. How is your child best comforted?

_____

_____

5. What are your child's favorite toys?

_____

6. What is your child's Sleeping Pattern: Please describe any specific ways in which you help your child to fall asleep:

_____

7. What is your child's current sleeping schedule?

Morning Nap: Begin _____ End _____

Afternoon Nap: Begin _____ End _____

Nighttime: Begin _____ End _____

Does your child use a pacifier at naptime? Yes No

Does your child use a special toy at naptime? Yes No

Does your child use a blanket at naptime? Yes No

Feeding

8. Is your child breast-fed? Yes No Bottle fed? Yes No

Brand of Formula: _____

What is your child's present eating schedule? (Please specify approximate amounts.)

Breakfast _____ Morning Snack _____

Lunch _____ Afternoon Snack _____

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Toileting

9. Does your child have diaper rash often? Yes No If so, how is it best treated?

_____

Additional Information

_____

_____

_____

Signature of Parent: _____ Date: _____

Signature of Parent: _____ Date: _____