Go-n-Play
DAY CARE & DROP IN CENTER

Infant Information

Please complete for your child ages 6 months to 18 months

Child's Name: _____ Child's DOB: _____

FEEDING:

Is your child on ☐ Breast Milk ☐ Formula ☐ Regular Milk?

What kind of milk or formula do you use? _____

How do they take their bottle? ☐ Room Temperature ☐ Warmed ☐ Cold

Does your child hold their own bottle? ☐ Yes ☐ No

Can they feed themselves? ☐ Yes ☐ No

Does your child eat any table food? ☐ Yes ☐ No If yes, please let us know what they can eat from the Go-n-Play menu. _____

Allergies to food: _____

Approximate Time	Types and Appropriate Amounts of Food

SLEEPING:

How does your child sleep? ☐ Stomach ☐ Back ☐ Side

Do you prefer your child to be rocked to sleep or not? ☐ Rocked ☐ Not Rocked

Please list the approximate times your child sleeps and/or naps.

OTHER INFORMATION:

Please list any special Diapering Information (i.e. diaper cream, cloth diaper) _____

Does your child take a pacifier? ☐ Yes ☐ No

******Please inform us if any of the above information changes.******

_____ _____

Signature Date