Learning Connections of Galesburg

INFANT FACT SHEET

Child's Name _____ Birthdate_____

Primary Contact's Name _____

HEALTH

Does your child seem well most of the time? Yes___ No (explain)_____
Does your child take any regular medications, vitamins, or laxatives? Yes _____ No ___
Are you concerned about your child's hearing? Yes _____ No _____
Are you concerned about your child's vision? Yes _____ No _____
Does your child have any disabilities? Yes _____ No ____
Has your child been hospitalized? Yes _____ No ____
Has your child had any of the following:
premature birth Yes _____ No ____
birth injury Yes _____ No ____
birth defects Yes _____ No ____
convulsions Yes _____ No ____
seizures Yes _____ No ____
asthma Yes _____ No ____
head injury Yes _____ No ____
Does your child have colic? Yes _____ No _____
If so, how do you treat it? _____
Is your child's skin highly sensitive to anything? _____

Are there any other significant illnesses that we need to know about? _____
_____

What arrangements have you made for the care of your child should he become ill at the center?
_____

DEVELOPMENT HISTORY

How do you comfort your child? _____
What are your child's favorite toys? _____
What are your child's favorite activities? _____
Does your child use a pacifier? Yes _____ No _____
Does your child suck his thumb? Yes _____ No _____
Does your child roll over stomach to back? Yes _____ No _____
Back to stomach? Yes _____ No _____
Does your child sit with support? Yes _____ No _____
Sit without support? Yes _____ No _____
Does your child crawl? Yes _____ No _____
Does your child pull up to furniture? Yes _____ No _____
Does your child stand without support? Yes _____ No _____
Does your child walk without support? Yes _____ No _____

Learning Connections of Galesburg

SLEEPING

Do you have any special ways of helping your child get to sleep? _____

_____

What is your child's present sleeping schedule?

Morning Nap from_____to_____

Afternoon Nap from_____to_____

Night Time from_____to_____

FEEDING

Is your child breastfed? Yes _____ No _____

If breastfed, does your child also take a bottle? Yes _____ No _____

Is your child formula fed? Yes _____ No _____

What type of formula do you use? _____

What type of bottle do you use? _____

How many ounces does your child typically consume at one feeding? _____

How many ounces does your child eat before he/ she needs to burp? _____

Has baby food or cereal been introduced? Yes _____ No _____

If so what kind? _____

Please describe your child's present eating schedule and typical foods offered:

Breakfast_____

Lunch_____

Snacks_____

Dinner_____

Does your child handle a cup or spoon? _____

Does your child eat in a high chair? Yes _____ No _____

Does your child eat at a table? Yes _____ No _____

Are there any other significant feeding issues that we need to know about? _____

_____

TOILETING

How frequently does your child have a bowel movement? _____

What time of the day? _____

Is diarrhea _____or constipation _____a problem?

If so, how do you treat it? _____

Is diaper rash a problem? Yes _____ No _____

If so, how do you treat it? _____

Are there any other facts that we should know about your child?_____

_____

_____