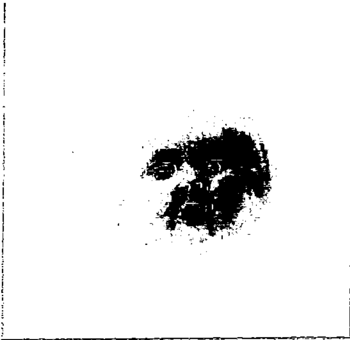

Ladybug Child Care Center

Getting to Know Your Infant

Child's Full Name: ______________________________
Child called: __________________ Date: ____________

Child Lives With:
Name: ____________________________ Relationship to child: ______________
Name: ____________________________ Relationship to child: ______________
Sibling's names & ages: ____

Non-Custodial Parents:
Name: ____________________________ Relationship to child: ______________
Does the child see this person? ___ Will this person interact with your child at the Center? ____
Any restrictions/limitations (COPY OF LEGAL DOCUMENTS MUST BE FURNISHED):_______

Health

Birthdate: _________ Birth Weight: __________ Birth Length: __________ Premature: Yes No
Does your child seem well most of the time? Yes No
Is your child taking any medications regularly (such as Tylenol, laxatives, vitamins, etc.) Yes No
If yes: what, why & when? ____
How many ear infections has child had in the past year? ___________________________
Has your child ever been seen by a medical specialist? Yes No
If yes, explain: ____
Has your child had any other illnesses/diseases? Yes No
If yes, explain: ____
Has your child had any serious accidents, hospitalizations, etc.? Yes No
If yes, explain: ____
Has your child had any of the following (please explain all that you marked):
_____ Birth injury or defect: ______________________________________
_____ Seizures: ____
_____ Breathing problems: ____
_____ Head injuries: ____
_____ Allergies **(prior to start date, this allergy must be noted on Health Care Summary by physician, an ICP must accompany enrollment paperwork, and parents must supply Ladybug with all medications listed on ICP)**
______Eczema, hives, drug/food intolerances, asthma/wheezing, insect stings:
____
_____Other: ____

Developmental History:

Has child been away from you before: Yes No How frequently? ______________
Has child been in a group before? Yes No If yes, explain: _________________
How does child handle separation from parent? Without upset briefly/mildly upset
Is your child easily frightened? Yes No If yes, explain: ____________________
How do you comfort your child? _____________________________________

Emotional Behavior (please circle all that apply):

Happy Calm Active Whining Excitable Cheerful Stubborn Crying Cooperative
Quiet Independent Wants Own Way Temper Tantrums Easily Angered

What are child's favorite toys & activities? ____________________

Sleep Patterns:

Describe any special ways of helping your child go to sleep? ____________________

____

Does your baby cry when going to sleep? Yes No If yes, for how long? ____________

What is your baby's present sleep pattern?

Night: from________ to________ from________ to________
AM Nap: from________ to________ from________ to________
PM Nap: from________ to________ from________ to________

At sleep times does baby need: pacifier/special blanket special toy

Other information: ____________________

____

Food Patterns:

How long has your baby been on a bottle? ____________________

What will your baby accept in the bottle? Breast milk formula fruit juice water

Does your baby drink from a: bottle cup both

Does your baby hold own: bottle cup both

Has your baby had any feeding problems? Yes No If yes, explain: ____________

Does your baby eat table foods? Yes No If yes, what types: ____________

Does your baby feed themself? Yes No If yes, what foods: ____________

Other information: ____________________

____

Toilet Patterns:

How often does your child have a bowel movement? ____________________

Is your child's average stool:

Very soft (like a newborn) soft firm (like an adult) very hard (pellet like)

Does your child often have a diaper rash? Yes No If yes, how is it treated? ________

Other information: ____________________

____

What would you like us to do for your child? ____________________

____

Suggestions to be more effective with your child: ____________________

____

Additional Comments: ____________________

____

____

Thank you for helping us get to know your child!