

DATE \_\_\_\_\_ CENTER \_\_\_\_\_



# CARING FOR YOUR CUDDLEBUG

To help us provide the best possible care, please take a minute to update the specific information about your child's daily routine.

## GENERAL INFORMATION

CHILD'S NAME _____	DAYS OF ATTENDANCE: <input type="checkbox"/> MON <input type="checkbox"/> TUES <input type="checkbox"/> WED <input type="checkbox"/> THURS <input type="checkbox"/> FRI
Are you aware of any allergies? <input type="checkbox"/> NO <input type="checkbox"/> YES* <i>(*If yes, please complete and attach an allergy action plan form.)</i>	

## FEEDING INFORMATION

Does your child take a bottle?  NO  YES\* *(\*Parents should make bottles in advance and label with child's first and last names.)*

Contents of the bottle are:  BREASTMILK  FORMULA  MILK  JUICE  WATER

When should bottles be given?  EVERY \_\_\_\_\_ HOURS

AT THESE TIMES: \_\_\_\_\_ AM/PM \_\_\_\_\_ AM/PM \_\_\_\_\_ AM/PM \_\_\_\_\_ AM/PM \_\_\_\_\_ AM/PM

ON DEMAND/AS NEEDED

If necessary, how much earlier than the indicated time may we provide a bottle? \_\_\_\_\_

Which of the following does your child eat, and when should they be served?

JAR FOOD: \_\_\_\_\_ AM/PM \_\_\_\_\_ AM/PM \_\_\_\_\_ AM/PM \_\_\_\_\_ AM/PM \_\_\_\_\_ AM/PM *(\*If applicable, please attach a copy of our center's menu, and highlight the items that you would like us to serve your child. Sign & date the menu and attach it to this form.)*

CEREAL: \_\_\_\_\_ AM/PM \_\_\_\_\_ AM/PM \_\_\_\_\_ AM/PM \_\_\_\_\_ AM/PM \_\_\_\_\_ AM/PM

TABLE FOOD\*: \_\_\_\_\_ AM/PM \_\_\_\_\_ AM/PM \_\_\_\_\_ AM/PM \_\_\_\_\_ AM/PM \_\_\_\_\_ AM/PM

If necessary, how much earlier than the indicated time may we provide a feeding? \_\_\_\_\_

**Parent Signature:** \_\_\_\_\_

## NAPPING INFORMATION

When does your child typically nap?  AT THESE TIMES: \_\_\_\_\_ AM/PM \_\_\_\_\_ AM/PM \_\_\_\_\_ AM/PM  ON DEMAND OR AS NEEDED

How long does your child typically nap? \_\_\_\_\_

If your child sleeps longer than usual, would you prefer that we wake him/her after specific amount of time?  NO  YES \_\_\_\_\_

If applicable, what is the latest time of day you would like your child to begin a nap? \_\_\_\_\_ AM/PM

Do you provide permission for your child to use a blanket in his/her crib?  NO  YES *(Parent's signature)* \_\_\_\_\_

*Back to sleep: Infants are placed on their backs to sleep, in accordance with New York State regulations and American Academy of Pediatrics recommendations. Infants with medical conditions that require other sleeping arrangements must have detailed written instructions from a physician on file.*

Does your child have a medical condition that requires special sleeping arrangements?  NO  YES *(Physician's instructions attached)*

## ADDITIONAL INFORMATION

Is there anything else you would like to share about your child's habits, preferences or capabilities?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**To be completed by infant lead teacher:**

Date received: \_\_\_/\_\_\_/\_\_\_

*(Please provide parents with a blank copy of this form monthly and upon request. Staple updates to the front of this page.)*

Allergy action plan received & reviewed:

Yes \_\_\_/\_\_\_/\_\_\_

Not applicable

Menu received & reviewed:

Yes \_\_\_/\_\_\_/\_\_\_

Not applicable