CARING FOR YOUR LITTLE ONE

DATE	CENTER NUMBER

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: ☐ MON ☐ TUES ☐ WED ☐ THURS ☐ FRI

Are you aware of any allergies? ☐ NO ☐ YES* *(*If yes, please complete and attach an allergy action plan form.)*

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

Cereal: _____AM/PM _____AM/PM _____AM/PM _____AM/PM _____AM/PM

Table 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.)*

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

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 a 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 over the age of 1? ☐ No ☐ Yes

Do you provide permission for your child to transition to sleeping on a cot when developmentally appropriate? ☐ No ☐ Yes

Back to sleep: Infants are placed on their backs to sleep, in accordance with 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 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

PARENT SIGNATURE