INFANT CARE INSTRUCTION SHEET

Name _____ Date of Birth _____

Does your child take a bottle? Yes or No Bottle warmed? Yes or No

When does your child normally take their bottle(s)? _____

Type of Diet: _____ Baby food _____ Finger foods

Can your child have: Cheerios _____ Goldfish _____ Puffs _____

Allergies: Food _____

Skin _____

Other _____

How do you normally get your child to sleep? (ex. Rocking, rub back, etc.)

_____

_____

Sleeping Position: On Stomach _____ On Back _____ On side _____

Does your child use a pacifier? Yes _____ No _____

OTHER HELPFUL INFORMATION (Please include specific schedule for feeding, sleeping, etc.)

_____

_____

_____

_____

_____

Parent Signature Date

In order to serve your infant's needs in an individualized manner, we ask that you fill this form out completely.