Maple Leaf
CHILDCARE CENTER

Infant Routine

Child's Name _____ D.O.B. _____/_____/_____

Parent's Names _____ Date _____/_____/_____

Feeding Schedule

How often does your child eat? _____

_____

Is your child on formula, breast milk or other milk?_____

What type of formula or other milk?_____

Feeding tips (burping, positioning):_____

_____

_____

Dietary Restrictions/Allergies:_____

_____

_____

Napping

Please tell us your child's "sleepy signs". _____

_____

How often does your child sleep? _____

Does your child use a pacifier or suck their thumb? _____

Does your child have a comfort item (favorite blanket, stuffed animal)?

_____

Soothing Techniques

How can we best comfort your child when they are upset (rocking, holding upright, walking, singing…)? _____

_____

_____

_____

Medical Information

Are there any medical or health issues that we should be aware of?_____

_____

_____

_____

Hints/Tips

Is there anything else that you would like to share to help us get to know your child and help them adjust to the room? _____

_____

_____

_____

_____

Parent Signature _____