

Infant Admission

Child's Name _____ Birthdate _____

Personal History

Type of Birth Normal____ Premature____ Complications_____

Who lives in the household? _____

What languages are spoken in the household? _____

What holidays/ special occasions does your family celebrate?

Does your child: Roll____ Crawl____ Stand____ Walk____

Health

Does your child have any medical concerns? Constipation____ Asthma____ Hay Fever____

Allergies_____ Other_____

Has your child had any of the following communicable diseases?

Measles (Big Red)____ Measles (3 Day)____ Mumps____ Chicken Pox____

Whooping Cough____

Has your child had any serious illnesses or hospitalizations? _____

Does your child have any physical disabilities? _____

Are there any medications given on a regular basis? _____

Sleeping Habits

What time does your child go to bed? _____ Awaken_____

Does your infant sleep through the night? _____

Where does your child take naps and sleep at night? _____

When does your child nap? Morning____ Afternoon____

Nap Schedule _____

Does your child use any of following to settle or to fall asleep?

Pacifier____ Sleep Sack____ Sound Machine____

Any other information regarding your child's sleep routine _____

Feeding

Please check the following that apply:

School Formula____ Home Formula____ Breastmilk____

School Food- Rice Cereal____ Oatmeal Cereal____ Gerber Fruit____ Gerber Vegetable____

Home Food Only____

School Solid Food: AM Snack____ Lunch____ PM Snack____

What is your child's feeding schedule? _____

Does your child have any dietary Restrictions or Food Allergies? _____

Are there any Food Allergies in the family? _____

Social Relationships

Who cares for your child when you are not with him/her? _____

How does your child relate to strangers? _____

What causes your child to become upset? _____

What techniques do you use to calm your child? _____

Comments