INFANT CARE SHEET

NAME _____ BIRTHDAY _____

ALLERGIES/SPECIAL NEEDS _____

_____

MEALTIME INSTRUCTIONS

BREAST MILK – FORMULA (CIRCLE ONE)

HOW OFTEN **_____** AMOUNT **_____**

JUICE: YES – NO (CIRCLE ONE)

HOW OFTEN_____ AMOUNT _____

CEREAL: YES – NO (CIRCLE ONE)

HOW OFTEN _____ AMOUNT _____

BABY FOODS

FRUITS: YES NO (CIRCLE ONE)

VEGTABLES YES NO (CIRCLE ONE)

MEATS YES NO (CIRCLE ONE)

HOW OFTEN: _____

AMOUNT: _____

SPECIAL INSTRUCTIONS _____

PACIFIER YES NO (CIRCLE ONE)

DIAPER OINTMENT YES NO (CIRCLE ONE)

POWDER YES NO (CIRCLE ONE)

LOTION YES NO (CIRCLE ONE)

PLEASE UPDATE INFORMATION EVERY 30 DAYS OR AS CHANGES OCCUR

I HAVE REVIEWED THIS FORM AND NO CHNAGES ARE NECESSARY FOR THIS 30 DAY PERIOD

1. SIGNATURE _____ DATE _____
2. SIGNATURE _____ DATE _____
3. SIGNATURE _____ DATE _____

YOUR CHILD WILL BE PLACED ON THEIR BACK FOR REST TIME UNLESS WE RECEIVE A LETTER FROM YOUR PHYSICIAN, STATING OTHERWISE