



All About Me

Child's Name: _____ DOB: _____

Parent/Guardian Names: _____

Is child Bottle or breast-fed? _____

How do you give bottle? (room temp, warmed, cold) _____

Does the child hold his or her own bottle? _____

Is your child on baby cereal? _____

Does your child require a special diet due to allergies, reactions and/or religious beliefs? _____

Is your child on strained or other baby foods? _____

List the varieties you use fruits/veggies etc: _____

Is your child able to feed themselves or do they require assistance? _____

Food Likes: _____

Food Dislikes: _____

When does your child nap? (morning, afternoon) _____

How do you help your child get ready for nap/bed? _____

Does your child need a special comfort item to sleep with? _____

How does your child sleep? (stomach, side, back) _____

Does your child use a dummy - if yes, when? _____

Does your child have any know health problems - if yes, please describe? _____

Do they require regular medication - if yes, what and when is it given? _____

Does your child have any know allergies - if yes, please list allergens? _____

Special instructions in case of an allergic reaction. _____

What are your child's favorite activity/ toy? _____

Please list any other important information or special instructions on the care of your child Below: _____

