



All About Me

Child's Name: _____ DOB: _____

Parent/Guardian Names: _____

Siblings: _____

Is your child bottle or breast-fed? _____

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

Does the child hold his/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 sleep? (Morning, afternoon) _____

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

Does your 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 known health problems – if yes, please describe? _____

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

Does your child have any known allergies – if yes, please list allergens? _____

Special instructions in case of an allergic reaction. _____

What are your child's favourite activities/toys? _____

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

