ROXBURY DAY CARE CENTER, INC.

Personal Information Record for Infants/Toddlers

Child's Name_____Age_____

1. What is your child's current daily sleeping schedule? _____
   Morning wake-up time: _____Evening bedtime:_____
2. Is your child sleeping through the night? _____
   Daily naps: _____
3. What upsets or frightens your child? _____
4. What does your child find soothing or comfortable? _____
5. How is your child now reacting to strangers? _____
6. Is your child using a cup, a bottle, or both? _____
   Are you breast feeding your child? _____At what times?_____
7. What are the times your child is now receiving the bottle each day? _____
8. How many ounces is your child taking at each bottle feeding? _____
9. Is your child taking formula, whole milk, skimmed or other? _____
10. Give any special instructions for preparing formula, if any:_____
    _____
11. Are there any other special instructions concerning bottle feeding your child? _____
    _____
12. Is your child now on baby food or table food? _____
13. Type of food: Amount per serving Times per day
    Cereal_____
    Fruit _____
    Meat/protein _____
    Vegetables _____
    Other fluids _____
    (juices, water, etc.)
14. Is your child now eating finger foods? _____Please list: _____
    _____
15. List any other foods your child is now eating:_____
16. Where does your child spend his/her waking hours? (Crib, playpen, crawling on floor, etc._____
    _____
17. What toys and activities make him/her happy?_____
18. When does your child usually have bowel movements?_____
19. Has your child begun potty training?_____If yes, describe his/her routine: _____
    _____
20. What does your child call his/her:
    Bowel movements: _____Urination: _____
21. Please use the other side of this paper for any other information you wish to share about your child.

Parent's Signature: _____Date: _____