Help Us to Know Your Infant

This form serves as a supplement to the "Help Us to Know Your Child" form. In order for us to provide the best possible care for your infant, please be as detailed as possible.

Child's Name:				Date of Birth:
Does your child take a bottle?		❑ Yes		❑ No
If so, is the bottle warmed?		❑ Yes		❑ No
Does your child hold his/her own bottle?		❑ Yes		❑ No
Does your child feed him/herself?		❑ Yes		❑ No
What foods does your child eat (circle those that apply):				
Baby Foods:	fruits	vegetables	meats	cereal
Strained Foods:	fruits	vegetables	meats	cereal
Snacks:	cheerios	crackers	goldfish	graham crackers
Table Foods:				Whole Milk?
Formula:				
Brand used:				Date:
Brand used:				Date:
Brand used:				Date:
What foods do your child especially like?	Are there foods your child dislikes?		Is there any food your child should not eat for medical, religious, or personal reasons?	
Please provide an approximate schedule of your baby's day:				
How would you like us to introduce solid foods to your infant?				

When changes are made to your child's diet or schedule, you MUST inform your child's teacher immediately.

_____ _____

Parent Signature Date

_____ _____

Print Name