

Ohio Department of Children and Youth
BASIC INFANT INFORMATION FOR CHILD CARE

<p>This information should be completed by the parents prior to the child's first day. This information should be updated periodically as the infant's needs change.</p>					
Child's Name			Nickname		
Child's Date of Birth			Siblings		
<p>What are you feeding your infant? <i>(Check all that apply)</i></p> <p> <input type="checkbox"/> Formula (include brand) <input type="checkbox"/> Breast milk </p>					
<p>Formula preparation <i>(if center/provider is to prepare.)</i></p>					
Amount for each feeding			Frequency of feedings		
<p>My infant likes a bottle warmed: <i>(Check one)</i></p> <p style="text-align: center;"> <input type="checkbox"/> Room temp <input type="checkbox"/> Warm <input type="checkbox"/> Very warm/NOT HOT </p>					
<p>Juice <i>(type, amount, when?)</i></p>					
<p>Does child use a cup yet? <input type="checkbox"/> No <input type="checkbox"/> Yes</p>					
<p>Solid foods <i>(baby food, brand, types, amounts, frequency)</i> <i>*you must have written permission from your child's physician if your child is under 4 months and given solid foods.</i></p>					
<p>Are foods served room temperature or warmed?</p>					
<p>Table food <i>(types, amounts, frequency, special instructions)</i></p>					
<p>Security items <i>(pacifier, blankies, etc.)</i></p>					
<p>Nap schedule</p>					
<p>Hints for getting baby to sleep</p>					
<p>Sleeping Position <input type="checkbox"/> Back <input type="checkbox"/> Side* <input type="checkbox"/> Tummy* <i>*You must secure a sleep position waiver from your child's physician if your baby is to sleep on their tummy or side. Please contact the center/provider for a DCY 01235.</i></p>					
<p>Special Precautions</p>					
<p>Any additional information about your child that would be helpful or you would like staff to know.</p>					
Parent Signature				Date	
Primary Caregiver Signature				Date	
Date form last updated					