

Infant Personal Data Sheet

Child's Name _____ Age _____ Date of Birth _____

Parent(s) Name _____

Address _____ Zip _____ Phone _____

Mother Employed By _____ Phone _____

Father Employed By _____ Phone _____

Usual Arrival Time _____ Usual Departure Time _____

I. Diet History

Liquids

Cup Bottle
 2% Milk Whole Milk
 Formula _____ (Brand)
 Heated Room Temperature Cool
 Amount/Serving _____
 Does baby hold own bottle? _____

Juice: Apple Grape Other

Solid Foods

Table Foods Baby Food
 Amount Serving _____

Vegetables

Peas
 Beets
 Carrots
 Green Beans
 Squash
 Potato
 Other

Fruits

Applesauce
 Pears
 Peaches
 Prunes
 Bananas
 Plums
 Apricots
 Other

Meats

Beef Veal Liver
 Turkey Lamb Pork
 Chicken Eggs Cheese

II. Daily Schedule

7:00am _____
 7:30am _____
 8:00am _____
 8:30am _____
 9:00am _____
 9:30am _____
 10:00am _____
 10:30am _____
 11:00am _____
 11:30am _____
 12:00pm _____
 12:30pm _____
 1:00pm _____
 1:30pm _____
 2:00pm _____
 2:30pm _____
 3:00pm _____
 3:30pm _____
 4:00pm _____
 4:30pm _____
 5:00pm _____
 5:30pm _____
 6:00pm _____

Diapering:

Powder Desitin
 Other _____

****Circle (above) any know food allergies****