Pathways to Play Early Learning Center

Infant Intake Form

Child's Name:____ Date of Birth:_________________________

Parent(s) Name(s):____

Health History: please circle yes (Y) or no (N) for each question listed.

Does your child seem well most of the time? Y N

Is your child taking any medications now (inc. aspirin, vitamins, laxatives, etc.)? Y N

If yes, what medications?______________________________

How often?____

In a year, has your child had three or more ear infections? Y N

Are you concerned with your child's hearing? Y N

Are you concerned about your child's eyes or vision? Y N

Does your child have any diagnosed disabilities or conditions? Y N

If yes, what?_______________________________________

Has your child been hospitalized within the last year? Y N

Has your child had any serious accidents or poisonings? Y N

Does your child chew unusual things, such as his crib, window ledges, paint chips, pencils, chalk, etc? Y N

Has your child had any of the following?

Premature birth	Y	N	
Birth injury or defect	Y	N	
Trouble breathing at birth	Y	N	
Convulsions or seizures	Y	N	
Allergies	Y	N	If yes, please list:___________________________

Sleeping:

Where does your child typically sleep?____

Do you have any special ways of helping your child to fall asleep?____

Please remember to complete the reverse side of this form

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What is your child's present sleeping schedule?____

____

Eating:

Is your baby breast-fed?_________________________ Is your baby bottle-fed?_____________________________

If your baby drinks formula, what kind? (Please note that PTP provides Similac Advance formula; if you will not be using this formula, a "decline letter" must be signed).____

How many ounces does your baby typically drink between burps?____

Is your child eating infant cereal, jar food, or table food?_____________________ (if yes, please complete attached form)

What is your child's current typical eating schedule (specify amount and time for milk/formula, and or/food):

____
____
____

Other Information:

How do you comfort your child?____

What are your child's favorite toys?____

What are your child's favorite activities?____

What language is spoken in your home?____

Does your child have any nicknames?____

Has your child been in a group care situation before?____

Does your child use a pacifier?____

Do you have any concerns about your child's development?____

____

Is there anyone who is restricted from picking up, visiting, or inquiring about your child?____________________________

____
____

What are your expectations for your child's experience at Pathways to Play?_____________________________________

____
____

Do you have any special interests or talents that you might wish to share with the children at the center?______________

____
____

We look forward to getting to know you and your child! J Pathways to Play Infant Room Staff

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