Child's Name:_____ **DOB:**_____

Feeding:

I drink _____oz every _____ hours.

I drink Breastmilk Formula Formula name/brand_____

I like my bottles: cool cold room temp. warm very warm

I can eat these solids:

_____

_____

Naptime:

I like to sleep on my: back tummy side any

I do do not use a sleep sack/swaddle.

I fall asleep best by: rubbing swinging patting other

Other:_____

Favorite Activities:

_____

_____

Any allergies/conditions to be aware of? Medications taken regularly?

_____

_____

Notes/Special Instructions:

_____

_____

Child's Name _____ Gender ____ Birthday _____

Home Address _____ Home Phone _____

Mother/Guardian's Name_____

Home Phone _____Cell Phone _____

E-mail Address: _____

Address _____

Employer _____ Hrs. from _____to _____

Employer Address _____

Business Phone _____

Father/Guardian's Name_____

Home Phone _____Cell Phone _____

E-mail Address: _____

Address _____

Employer _____ Hrs. from _____ to _____

Employer Address _____

Business Phone _____

Physician's Name_____

Address_____

Phone_____

Insurance Information_____

Emergency Contact Name_____

Home Phone_____ Cell Phone_____

Address_____

Relationship_____

Infant Supply List

These are things that can either be brought daily in a diaper bag, or brought in to store and replenished as necessary.

- ☐ Diapers
- ☐ Wipes
- ☐ Diaper cream
- ☐ Pacifiers
- ☐ Burp clothes
- ☐ Bibs
- ☐ Gripe water/gas drops
- ☐ 3-4 extra outfits
- ☐ Swaddle/sleep sack
- ☐ Nose bulb
- ☐ Extra empty bottles
- ☐ Formula if bottles are not pre-made
- ☐ Favorite blanket/lovie/soothing item