# Older Infant Diet and Sleeping Record

Infant Name: _____ D.O.B. _____

## Feedings

Does your child have any known allergies?  **YES**        **NO**        Known allergies _____
My child drinks:                **Formula**        **Breast Milk**    **Whole Milk**
Brand of Formula: _____
My child has _____ ounces every _____ hours
I will provide food for my child everyday        **YES**    **NO**
I will use the food provided by Growing Generations        **YES**    **NO**

## My Child Eats (Please Circle):

Cereal          Jar Food        Table and Jar foods
Table Foods    Homemade Foods      Bottles only

Please list any table food your child CAN NOT have or if your child has any dietary restrictions:
_____

Special Instructions for feedings:
_____

## Developmental History:

Has your child been away from you before? _____ Yes      _____ No        How Frequently? _____
Has your child been in group before? _____ Yes      _____ No       If yes, explain _____
How does your child handle separation from parent? _____ Without upset          _____ Briefly/mildly upset
Is your child easily frightened? ? _____ Yes          _____ No       If yes, explain _____
How do you comfort your child? _____
Emotional Behavior (please indicate all that apply):
__ Happy        __ Calm        __ Active        __ Cheerful    __ Stubborn    __ Cooperative

__ Quiet        __ Independent        __ Crying

What are child's favorite toys and activities? _____

## Sleep Patterns:
Describe any special ways of helping your child go to sleep? _____

_____

Does your baby cry when going to sleep? _____ Yes ___ No        If yes, for how long? _____
What is your baby's present sleep patter?
    Night:        from _____ to _____        from _____ to _____
    AM Nap:    from _____ to _____        from _____ to _____
    PM Nap:    from _____ to _____        from _____ to _____

Other sleep information: _____

**Toilet Patterns**:
How often does your child have a bowel movement? _____

Is your child's average stool:
_____ Very Soft (like a newborn)     _____ soft     _____ firm (like an adult)     _____ very hard (pellet like)

Does your child often have a diaper rash? _____ Yes ___ No       If yes, how is it treat? _____

My child uses this brand of Diapers: _____ Size: _____
My child uses this diaper ointment: _____

Other toileting information: _____


Parent Signature: _____ Date: _____

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