Play& Learn

Infant Profile

Child's Name: _____

Center: _____

Program: _____

"Getting to Know You" Date: _____

Play & Learn

Dear Parents,

Welcome to Play & Learn! In order to better understand your child, we have designed this booklet to allow you to share information concerning your child's personal habits, skills, and health. This profile will give us a "head start" in attaining our goal of meeting your child's needs. Feel free to include any additional information and concerns.




GENERAL INFORMATION

Child's Full Name: _____

Nickname: _____

Birthdate: _____ Age: _____

Parent Names: _____

_____

If child is not in care of parents, please list guardian name(s):

_____

_____

What is the marital status of parents?

_____ Married _____ Divorced _____ Separated _____ Single

Are both parents living in the house with the child? _____ Yes _____ No

Please list all siblings:

Name	Age
_____	_____
_____	_____
_____	_____

Please list anyone else living in the house with the child:

Name	Relationship
_____	_____
_____	_____
_____	_____

Who will be dropping off your child? _____

Who will be picking up your child? _____

FEEDING

Is your child breastfed or bottle fed? _____

Please list your child's feeding schedule below.

TIME	FOODS	QUANTITY

How long does a feeding usually take? _____

How often does your child need to be burped, and what technique do you use? _____

_____

_____

Does your child spit up? If so, please provide details: _____

_____

_____

Does your child drink formula? _____ Yes _____ No

If so, please list brand and type of formula: _____

_____

Does your child drink milk? _____ Yes _____ No

If so, what kind?

_____ Whole _____ 2% _____ 1% _____ Skim _____ Other

If other, what kind of milk does your child drink? _____

Does your child drink juice? _____ Yes _____ No

If so, what kinds? _____

Can your child use a spoon? _____ Yes _____ No

Please check all the foods below that your child has had:

Meats _____ Fruits _____ Vegetables _____ Cereal _____

Other _____

If you checked cereal, what type(s) has your child had? _____

_____

Can your child use a cup? Please describe: _____

_____

_____

_____

Please describe any other feeding information you feel is important: _____

_____

_____

_____

_____

_____

NAPPING

What are your child's usual nap times? _____

_____

In what position does your child sleep? _____

_____

Does your child use a pacifier at nap time? _____ Yes _____ No

How do you usually put your child to sleep? _____

_____

_____

Please list any other napping habits: _____

_____

_____

DIAPERING

How often does your child have a bowel movement and what is the usual consistency? _____

_____

_____

Does your child get diaper rash often? _____

How do you treat your child's diaper rash? _____

_____

Other Comments: _____

_____

_____

PLAY SKILLS

Does your child do any of the following? Please check all that apply.

Roll _____ Crawl _____ Sit Up Alone _____ Pull to Stand _____
Use a Walker _____ Walk Alone _____

Does your child like any of the following? Please check all that apply.

Be rocked _____ Use a Swing _____ Lie on Back _____ Be Sung to _____

Lie on Stomach _____

What are your child's favorite toys? _____

_____

What games do you play with your child? (i.e. peek-a-boo, pat-a-cake) _____

_____

Other Comments: _____

_____

_____

COMMUNICATION SKILLS

What does it usually mean when your child cries? _____

_____

How does your child let you know that s/he:

- Is hungry _____
- Has a dirty diaper _____
- Is sleepy _____
- Wants to be held _____
- Other _____

Does your child use any words? If so, please list the most important words: _____

_____

_____

_____

Does your child follow simple directions? If so, please describe: _____

_____

_____

_____

Other Comments: _____

_____

_____

_____

PERSONAL CHARACTERISTICS

Circle the characteristics that seem to describe your child:

Relaxed Happy Demanding Outgoing Energetic
Stubborn Cooperative Quiet Sensitive

How does your child generally react to new experiences or unfamiliar people? _____

_____

_____

_____

What frightens your child? _____

_____

_____

What frustrates your child? _____

_____

_____

How do you calm your child? _____

_____

_____

MEDICAL INFORMATION

Please provide information if your child has a history of any of the following conditions.

	Date	Circumstances
Allergy		
Asthma		
Concussion		
Convulsions		
High Fevers		
Seizures		
Serious Falls		
Serious Injury		
Chronic Illness		
Hospitalization		
Other		

Describe any history of visual problems: _____

_____

Describe any history of hearing problems: _____

_____

Please list your child's current medication(s): _____

_____

_____

Please list the condition(s) that the medication(s) treat: _____

_____

_____

Please list any other current medical issues: _____

_____

_____

_____

How would you describe your child's general health? _____

_____

_____

_____

Please describe any physical handicaps or limitations: _____

_____

_____

_____

Please describe any special dietary needs and/or food allergies: _____

_____

_____

_____

Are there any other special concerns that we need to know? _____

_____

_____

_____

Are any early intervention services provided for your child? If yes, please describe: _____

Please provide your center director with IFSP or IEP documentation if applicable.

Please describe any helpful hints that will enable us to best work with your child: _____