



Play &  
Learn  
— est. 1981 —

# Infant Profile

**Child's Name:** \_\_\_\_\_

**Center:** \_\_\_\_\_

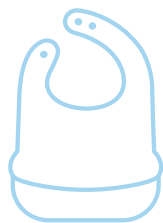
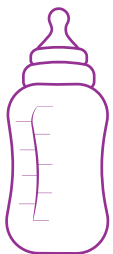
**Program:** \_\_\_\_\_

**"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?

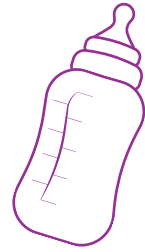
\_\_\_\_\_

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?

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Can your child use a cup? Please describe:

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Please describe any other feeding information you feel is important:

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## NAPPING

What are your child's usual nap times?

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In what position does your child sleep?

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



How do you usually put your child to sleep? \_\_\_\_\_

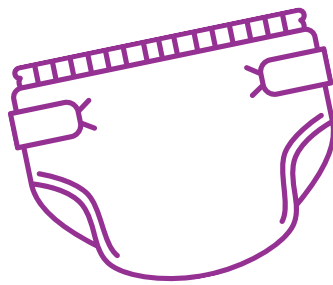
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Please list any other napping habits: \_\_\_\_\_

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## DIAPERING

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

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Does your child get diaper rash often? \_\_\_\_\_

How do you treat your child's diaper rash? \_\_\_\_\_

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Other Comments: \_\_\_\_\_

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## 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? \_\_\_\_\_

\_\_\_\_\_

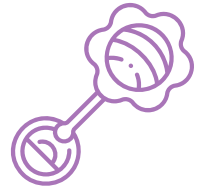
What games do you play with your child? (i.e. peek-a-boo, pat-a-cake) \_\_\_\_\_

\_\_\_\_\_

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: \_\_\_\_\_

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

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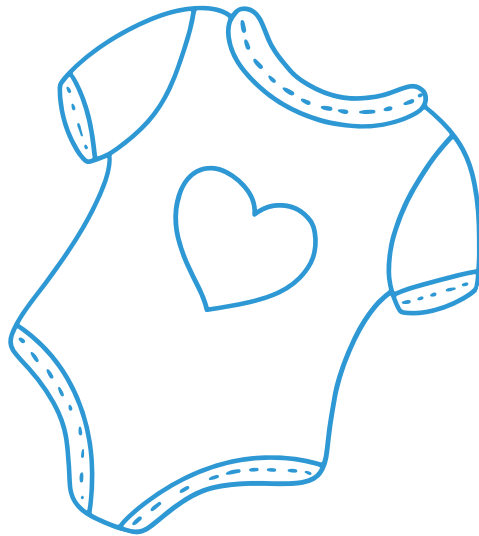
Other Comments: \_\_\_\_\_

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What language does your child and family speak? \_\_\_\_\_





# PERSONAL CHARACTERISTICS

Please check off 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?

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What frightens your child?

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What frustrates your child?

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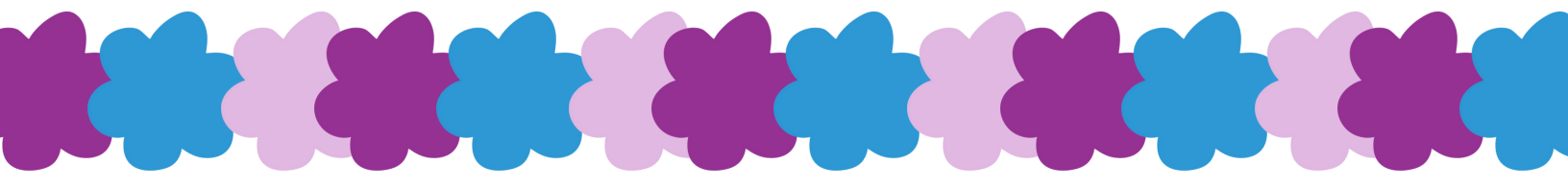
How do you calm your child?

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# 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:

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How would you describe your child's general health?

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Please describe any physical handicaps or limitations:

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

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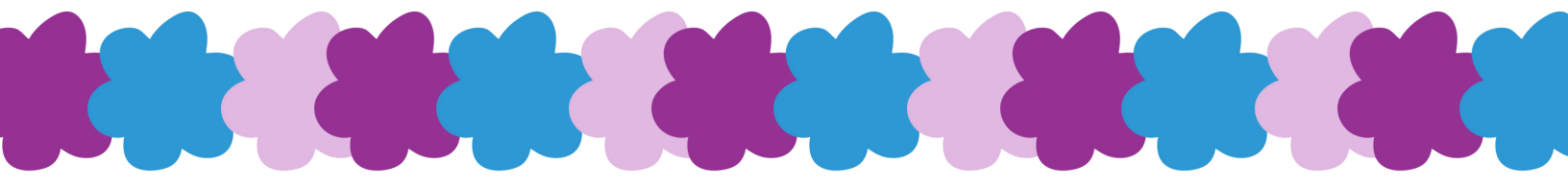
Are there any other special concerns that we need to know?

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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.)

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

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