INFANT CARE INSTRUCTION SHEET

NAME: _____ DATE OF BIRTH: _____

Type of Formula (be specific): _____ Warmed: ____Yes ____ No

Water: ____Yes ____No Type of Juice: _____

Please list the solids your child is eating: Cereal: _____

Vegetables	Fruits	Meats
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies

Food: _____ Symptoms: _____

Skin: _____ Symptoms: _____

Other: _____ Symptoms: _____

Preferred Sleeping Position: ____ On Back ____ On Stomach (if rolling over) ____ On Side (Dr. Approval)

Pacifier ____Yes ____No Sleep Sack ____ Yes ____ No Swaddle ____ Yes ____ No

Feeding Schedule:

Bottle every _____ hours

Solids every _____ hours

Nap Schedule:

Every _____ hours

Sleep no longer than _____ hours (optional)

Sleep no later than _____ o'clock (optional)

Other helpful information: _____

_____

_____

NO UPDATE Initials	PARENT SIGNATURE	DATE
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____