Please complete this form to help us provide the best care for your child. Turn in completed forms at the Self Check-In desk. Please keep it updated as the needs of your child change.

Child's Name_____ D.O.B_____ Home Phone #_____

Home Address _____

Parent Name(s) _____ _____

E-mail _____

Who is allowed to pick your child up?

1._____ 2._____ 3. _____ 4. _____

CONTACT INFORMATION: During service put your phone on vibrate and we will use this number to contact you if needed. Cell #_____

ALLERGIES/MEDICAL CONDITIONS: No / Yes – give details

_____

_____

FEEDING ROUTINE: Bottle / Baby Food / Nursing/ Sippy Cup Eats every _____hrs _____oz

Warm bottle Yes/No Warm baby food Yes/No Reflux Yes/No

Can your child eat Puffs? Yes/No

SLEEPING ROUTINE:

Rock to sleep Yes/No Lay in bed to sleep Yes/No Pacifier Yes/No Blanket Yes/No

Sleeps on: Side Yes/No Tummy Yes/No Back Yes/No

BEST WAY TO SOOTH YOUR CHILD:

_____

_____

ADDITIONAL INSTRUCTIONS OR INFORMATION:

_____

_____

Please label all bottles, cups, pacifiers, blankets, etc. with your child's name

BED BABIES CREEPERS