AUGUST HOME DAYCARE

Infant Social Resume

Child's Name: _____

Does your child have a nickname? ☐ Yes ☐ No If Yes, what is it? _____

Family

Names of others living in the home	Relationship to child
_____	_____
_____	_____
_____	_____

What languages are spoken in your home? _____

Does your child have any pets? ☐ Yes ☐ No If Yes, what are they? _____

Food

Is your child **breast-fed**? ☐ Yes ☐ No

If **Yes**:

Do you plan to continue breast-feeding? ☐ Yes ☐ No

If Yes, how do you plan to carry this out? _____

_____

What is your child's feeding schedule? _____

_____

Do you supplement? ☐ Yes ☐ No If Yes, with what and how often? _____

_____

Is your child **bottle-fed**? ☐ Yes ☐ No

If **Yes**: What is your child's bottle feeding schedule? Please complete chart:

Liquids	Type	Amount	Times
Formula			
Milk			
Water			
Other:			

What position does your child like to be in while bottle-feeding? _____

_____

What position does your child like to be in while being burped? _____

_____

_____

Does your child spit-up? Please comment: _____

_____

Has your child been introduced **to solids**? ☐ Yes ☐ No If Yes, what type? ☐ Baby food ☐ Table food

What is your child's feeding schedule? Please complete chart. (Only list foods to which your child has successfully been introduced)

Solids	Type	Consistency	Amount	Times
Cereals				
Cereals				
Cereals				
Vegetables				
Vegetables				
Vegetables				
Vegetables				
Fruits				
Fruits				
Fruits				
Fruits				
Meats				
Meats				
Snacks				
Snacks				

Does your child have any food sensitivities? ☐ Yes ☐ No If Yes, please identify: _____

Describe your child's appetite: _____

What foods does your child like and dislike? _____

Sleep

Describe your child's sleep routine (include times and lengths of naps) _____

Describe ways you help your child go to sleep (include position, special blanket, lighting, sound, etc.)

Does your child usually cry when going to sleep? ☐ Yes ☐ No If Yes, for how long? _____

Does your child usually cry when waking? ☐ Yes ☐ No

Where does your child usually sleep? Please describe: _____

Diapering

What type of diapers does your child use? _____

Describe your child's normal diapering routine (include double-diapering, liners, creams, powders, etc.)

_____

_____

Is your child prone to diaper rash? ☐ Yes ☐ No Treatment used: _____

_____

How many diapers would your child normally use between 8:00 a.m. and 5:00 p.m.? _____

Please comment on your child's bowel movements (including frequency, color, consistency, constipation, etc.)

_____

_____

Social/Emotional Development

Describe your child's temperament: (i.e. colic, likes to cuddle) _____

_____

What signs does your child give of being hungry, tired or over stimulated? (i.e. pulls at ears, rubs eyes) _____

_____

Does your child separate easily from you? ☐ Yes ☐ No Please comment: _____

_____

Is your child afraid of anything? ☐ Yes ☐ No Please describe: _____

_____

Does your child have a favorite toy, blanket, bottle or soother? ☐ Yes ☐ No Please identify: _____

_____

Does your child spend time with other children? ☐ Yes ☐ No Please comment: (who, when, how much)

_____

_____

What activities does your child enjoy? _____

_____

What activities does your child dislike? _____

_____

Provide any further information relating to your child that would be helpful in understanding and caring for your child.

_____

_____

_____

_____

Date: _____ / _____ / _____
Year Month Day

_____
Parent/Guardian Signature

AUGUST HOME DAYCARE

Child's Health Resume (Required Form)

AUGUST HOME DAYCARE

Child Care Regulation 36 requires every licensee to keep a record with respect to each child attending the facility that includes: (a) child's name and date of birth, (b) names, addresses and telephone numbers of the child's parents, persons to contact in the case of an emergency and the child's medical practitioner, (c) any allergies, illness or other medical condition and (d) the child's immunization status.

Child's Name: _____ Starting Date: _____/_____/_____
Year Month Day

Date of Birth: _____/_____/_____
Year Month Day

Parent/Guardian Name: _____ **Parent/Guardian Name:** _____

Home Address: _____ Home Address: _____

Postal Code: _____ Postal Code: _____

Home phone: _____ Home phone: _____

Place of business: _____ Place of business: _____

Business phone: _____ Business phone: _____

Cell phone: _____ Cell phone: _____

Email: _____ Email: _____

Are both parents listed above authorized to remove the child from the child care facility? ☐ Yes ☐ No

Comments: _____

_____

In case of emergency, the Childcare provider will contact the following physician for medical treatment:

Physician's Name: _____

Address: _____

Phone: _____

Provide the names of two other persons to contact in case of emergency.

1. **Name:** _____ 2. **Name:** _____

Relationship: _____ Relationship: _____

Home phone: _____ Home phone: _____

Business phone: _____ Business phone: _____

Cell phone: _____ Cell phone: _____

Email: _____ Email: _____

AUGUST HOME DAYCARE

Medical History

Check (√) any of the following illnesses which the child has had:

☐ Asthma	☐ Earaches	☐ Mumps	☐ Whooping cough
☐ Bronchitis	☐ Eczema	☐ Pneumonia	☐ Injuries – please list _____
☐ Chickenpox	☐ Frequent colds	☐ Polio	_____
☐ Convulsions	☐ Influenza	☐ Rheumatic fever	☐ Other - please list _____
☐ Croup	☐ Measles (German)	☐ Scarlet fever	_____
☐ Diphtheria	☐ Measles (red)	☐ Tonsillitis	_____

Are your child's immunizations up to date? ☐ Yes ☐ No

Allergies

Does your child have any known **drug** allergies? ☐ Yes ☐ No If Yes, what are they, and what are your child's reactions?

_____

_____

Does your child have any known **food** allergies? ☐ Yes ☐ No If Yes, what are they, and what are your child's reactions?

_____

_____

Does your child have any **other** allergies? ☐ Yes ☐ No If Yes, what are they, and what are your child's reactions?

_____

_____

Other Medical Information

Does your child take any medication on a regular basis? ☐ Yes ☐ No If Yes, please give the name of the medication and the medical condition for which it is taken. (**Must fill-out Medication Form**) _____

_____

Are there any restrictions on the kind and/or amount of physical activity in which your child may participate?

☐ Yes ☐ No If Yes, please identify. _____

_____

Has your child ever undergone surgery? ☐ Yes ☐ No If Yes, please list. _____

_____

_____

Are there any special diets necessary for your child's health? ☐ Yes ☐ No If Yes, please describe._____

_____

_____

Please comment on any other medical information the child care service should be aware of._____

_____

_____

_____

Date: _____/_____/_____ _____

Year Month Day Parent/Guardian Signature