Minnesota JCC

Early Childhood Center

Infant Classroom Intake

Child's Name:_____ **Date of Birth:**_____

Parent/Guardian's Name(s):_____

GETTING TO KNOW YOUR FAMILY

Expected drop-off and pick-up Hours:_____

Which parent/guardian should we call first if we should need to contact you?_____

Do you prefer contact through Daily Connect or a phone call?_____

Do you follow a particular parenting philosophy?

_____

Has your child been enrolled in childcare before? ☐ **Yes** ☐ **No**

If yes, what did you like or not like about that experience?

_____

Who are the important adults in your child's life?_____

Sibling(s) Name(s) and age(s)_____

Any pets?_____ Language spoken at home?_____

Are there any routines or spiritual/religious practices that we should be aware of?

_____

Are there any other cultural aspects that you want to incorporate into your child's day?

_____

GETTING TO KNOW YOUR CHILD

Do you have any nicknames for your child?_____

What are your child's favorite activities? Favorite toys, books, songs?

_____

_____

How does your child handle being separated from you?

_____

How does your child like to be held?_____

Has your child started teething? If so, what is teething like for them?

_____

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Does your child like tummy time?_____

Has anyone expressed concern about any aspect of your child's development?

_____

_____

Any birthmarks or other colorations?_____

SLEEPING

Please describe how your child typically falls asleep: _____

_____

Does your child typically cry when falling asleep? ☐ **Yes** ☐ **No**

Does your child use a pacifier? ☐ **Yes** ☐ **No** Does your child use a sleep sack? ☐ **Yes** ☐ **No**

What is your child's present sleeping pattern?

AM	TO
PM	TO
PM	TO
BED	TO

What does your child's routine/going down for nap at home look like?

_____

_____

_____

FEEDING

Is your baby breast fed? ☐ **Yes** ☐ **No** Does your child drink formula? ☐ **Yes** ☐ **No**

Will you be coming to the center to nurse your baby? If yes, when?_____

Has your baby had success drinking from a bottle? ☐ **Yes** ☐ **No**

What type of bottle do you use?:_____

Bottle temp? ☐ Warm ☐ Room temperature ☐ Cold

How often does your baby need to burp?:_____

If your child is using a cup, when are you offering a cup?_____

Open cup or sippy cup?_____ What do you offer in the cup?_____

Does your child have any difficulty feeding? ☐ **Yes** ☐ **No**

If so, please describe: _____

If your child is under a year old and eating solids, do you have a preference on order of bottles and solids are given?_____

Please share your baby's eating schedule including typical amounts:

	Bottles
Time:	**Amount (oz):**
Time:	**Amount (oz):**
Time:	**Amount (oz):**

	Solids
Breakfast	
Lunch	
Snack	

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EXPECTATIONS FOR CHILDCARE

What kind of information would you like to get from your child's teacher?

_____

_____

What types of things do you want to hear about your child's daily experiences?

_____

_____

Do you want to know firsts (crawling, pulling self up, walking) if they happen with us?

_____

_____

What are your expectations for your child's experience at the center?

_____

_____

Is there anything else that you would like us to know?

_____

_____