INFANT REGISTRATION FORM

Please complete all fields on this registration form as all information is required by MN DHS.

INFANT'S INFORMATION

Last Name: _____ First Name: _____
Nickname: _____ Birth Date: _____
Address: _____ City, State, Zip: _____
Start Date: _____ Classroom: _____

Name of siblings and birthdates: _____
Most recent child care provider: _____ (circle): In Home / Center
Who does the infant live with? _____

FAMILY INFORMATION

MOTHER / GUARDIAN #1:

Last Name: _____ First Name: _____
Relationship to Infant: _____ Cell Phone: _____
Address: _____ Can you receive texts? (circle one) Yes / No
City, State, Zip: _____ Employer: _____
Email: _____ Work Phone: _____
Which is the best method of communication during the day? Work / Cell / Email / Text Cell

FATHER / GUARDIAN #2:

Last Name: _____ First Name: _____
Relationship to Infant: _____ Cell Phone: _____
Address: _____ Can you receive texts? (circle one) Yes / No
City, State, Zip: _____ Employer: _____
Email: _____ Work Phone: _____
Which is the best method of communication during the day? Work / Cell / Email / Text Cell

EMERGENCY INFORMATION

EMERGENCY CONTACTS

Name: _____ Relationship to Infant: _____
Address: _____ Work / Cell Phone: _____
Name: _____ Relationship to Infant: _____
Address: _____ Work / Cell Phone: _____

AUTHORIZED PICK UP

Your infant will ONLY be released to an authorized person listed on this form above (parent / guardian and/or emergency contact). In case of an emergency or an unforeseen circumstance, please indicate the name, address and phone number of any other persons who you authorize to pick up your infant on your behalf. All blanks must be filled in.

	Name	Address	Phone
1.			
2.			

A parent / guardian's verbal authorization for pick up must be received before your infant will be released to anyone not listed above. If not received, and we cannot get in touch with you by phone, your infant will NOT be released

MEDICAL / DENTAL INFORMATION

Pediatrician: _____ Office Phone: _____

Address: _____ City, State, Zip: _____

Medical Insurance Co: _____ Infant's Personal ID# _____

Allergies or Medical conditions / needs: _____

Dentist: _____ Office Phone: _____

Address: _____ City, State, Zip: _____

Please use your dentist even if your infant is not yet being seen. All blanks must be filled in

EMERGENCY CONSENT

It is our policy to notify a parent when a child is ill or needs medical attention. Occasionally, we cannot contact a parent and we need to get immediate help for the child. Our procedure is to take the child to the nearest emergency service.

Please sign below so that we may take appropriate action on behalf of your child.

I / WE HEREBY GIVE MY / OUR CONSENT FOR MY CHILD _____ WHEN ILL / INJURED TO BE TAKEN TO THE NEAREST EMERGENCY CENTER BY THE STAFF OF NEW CREATIONS CHILD CARE AND LEARNING CENTER WHEN I / WE CANNOT BE CONTACTED. I CONSENT TO AN AMBULANCE BEING CALLED TO TRANSPORT THE CHILD, IF NECESSARY. I FURTHER AGREE TO PAY ALL COSTS INCURRED FOR TRANSPORT.

_____ _____

Parent / Guardian Signature Date

_____ _____

Director Signature Date

HEALTH AND MEDICAL HISTORY

Has your infant ever had any of the following? Check all that apply.

☐ Chicken Pox	☐ Scarlett Fever	☐ Diabetes	☐ Measles
☐ HIV	☐ Aids	☐ Hepatitis A	☐ Hepatitis B
☐ Mumps	☐ Asthma	☐ Other – Explain:	_____

Does your infant frequently have any of the following? Check all that apply.

☐ Ear Aches ☐ Colds ☐ Sore Throat ☐ Stomach Aches

Does he / she vomit easily? (circle one) Yes / No
Run high fevers easily? (circle one) Yes / No
Has your infant had any serious accidents? (circle one) Yes / No If yes, please explain:

Does your infant have any allergies? (circle one) Yes / No If yes, please explain what allergies your infant has and when / how it manifests (asthma, hay fever, hives, etc.):

Has your infant ever been hospitalized? (circle one) Yes / No If yes, please explain:

Has your infant ever been to a dentist? (circle one) Yes / No
Does your infant have any disabilities or exceptionalities we need to be aware of? (circle one) Yes / No If yes, please explain:

How do you find your infant's overall health to be?

GETTING TO KNOW YOUR INFANT

DAILY INFORMATION

Was your infant born (circle one): Premature / Full Term Birth Weight
Was your infant born (circle one): At Home / At a Hospital
How is your infant's general mood?
Has your infant ever spent the night with anyone besides their parents? (circle one) Yes / No
If yes, whom?
Is you infant bottle or breastfed? (circle one) Bottle / Breastfed
If not breastfed, does your infant drink milk or formula? (circle one) Milk / Formula
What kind of milk or formula do you use?
Does your infant like his / her bottle: (circle one) Warm / Room Temperature / Cold
How many ounces does your infant typically drink at a time?
Does your infant eat cereal? (circle one) Yes / No
Does your infant eat baby foods? (circle one) Yes / No
How often does your infant eat?
How much does he / she eat at once?
If eating foods, what foods does your infant like / dislike?

If applicable, please list amounts and types of food your infant generally eats below:
Breakfast:
Lunch:
Snack:

***each time there is a change in your infant's feeding schedule, his / her teacher will need the change in writing. A new dietary form can be picked up from the classroom.**

Will your infant have a bottle/be breastfed before arriving in the morning? (circle one) Yes / No
Will your infant need breakfast? (circle one) Yes / No
Does your infant use a pacifier? (circle one) Yes / No When? _____
How do you put your infant to sleep? (Crib, Rocked, Back patted, etc)

_____

Does your infant sleep through the night? (circle one) Yes / No
If not, how often does he / she wake and what do you do when they wake?

_____

When does your infant wake in the morning? _____
When does your infant take his / her morning nap? _____ Afternoon Nap? _____
For nap, my infant needs a: (circle all that apply) Nuk / Sleep Sac / Other _____
How does your infant communicate? _____
Please make any special or important notes below:

_____

RELATIONSHIPS, FAMILY, CUSTOMS, AND SOCIAL / EMOTIONAL INFORMATION

What are your infant's favorite toys and/or activities?

_____

How does your infant interact with others?

_____

Are there things that your infant does not like that may make him or her feel upset / angry?

_____

Is there anything your infant is afraid of?

_____

Does your infant enjoy listening to stories?

_____

Does your infant have a favorite song to sing at home?

_____

Are there any other languages spoken at home other than English?

_____

Are there any cultural or special customs or traditions that your family celebrates at home?

_____

What are some effective ways for comforting your infant?

_____

_____ _____ _____
Parent / Guardian Signature Relationship to Infant Date

TO BE FILLED OUT BY NEW CREATIONS

Parent / Teacher Conference Date #1 _____
Summary: _____

_____

Parent / Teacher Conference Date #2 _____
Summary: _____

_____