

# Infant Information

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Parent(s) Names: \_\_\_\_\_

Feeding Schedule  
Times

Sleeping Schedule  
Times


## Important Little Notes

Brand of Formula	
Brand of Diapers	
First/Favorite Foods	
First/Favorite Foods	
Allergies	
Sleep on stomach?	

Special things your child likes to do:

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Parent Signature \_\_\_\_\_ Date \_\_\_\_\_