



ADVENTURE MONTESSORI
LEARNING, INC.

INFANT INTAKE FORM

Child's Name: _____ Date of Birth: _____

Name child goes by: _____

Parent 1 Name: _____ Daytime Phone #: _____

Parent 2 Name: _____ Daytime Phone #: _____

Sibling(s) Name(s) and Age(s):

Other people living in the household:

Do you have any pets? If so, what are their names?

What is your child's primary language? _____

Secondary language? _____

Do you have any concerns about your child's language development?

Do you and your child know baby sign language? Yes No

If so, what signs? _____

EATING / SLEEPING ROUTINES

Does your child drink from a sippy or regular cup? (Please circle)

What stage is your child at in eating development? Nursing/Bottle Spoon fed Self Feeds

Please describe your child's daily eating routine:

Favorite foods:

Is your child on a specific diet; e.g. vegetarian, dairy free or other?

How many hours does your child sleep at naptime? _____ Time(s) of day _____

At what time does your child go to bed at night time? _____

Does your child sleep through the night? Yes No

Does your child sleep with: Pacifier Blanket Toy Bottle?

Describe your child's sleep time routine:

Does your child sleep in a crib, floor bed, family bed? Please describe:

CHILD CARE HISTORY

Does your child have prior experience with caregivers and/or babysitters?

Please explain: (caregiver and setting, frequency, length of time, etc.)

Was this care a positive experience for you and your child? Yes No

Please comment:

MEDICAL HISTORY

BIRTH

Was your child premature? Yes No

If yes, at how many weeks of pregnancy was the birth? _____

Was the pregnancy/delivery normal? Yes No

If no, Explain:

SINCE BIRTH

Does your child have any allergies, medical conditions and/or chronic health concerns? Yes No

If yes, Explain:

Does your child seem well most of the time? Yes No

Have your child's eyes ever looked crossed? Yes No

Does your child have frequent ear infections? Yes No

If so, how many?

Does your child have ear tubes? Yes No

Explain any special precautions we must take:

Does your child have any suspected or known special needs/handicaps? Yes No

If yes, please describe:

Has your child Ever had surgery? Yes No

If yes, please explain:

Has your child experienced any emotional trauma (Other than what is listed above)? Yes No

If yes, please explain:

Is your child given any medication regularly? Yes No

List:

Is there anything else pertaining to your child's health that you wish to share with us?

Parental Permission for the use of Floor Beds in the Nido Community at Adventure Montessori Learning.

I _____, the parent or legal guardian of
parent's/guardian's printed name

_____, agree and understand that my child has my permission to use
child's printed name

A floor bed for nap time knowing that he/she will be well monitored and that this freedom spontaneously explore the surrounding child-safe environment is an enhancement to his/her developmental growth.

Parent's signature _____ Date _____

Thank you!

We look forward to a healthy and satisfying relationship with you and your family.