

# SUPPLEMENTARY FORM FOR CHILDREN UNDER 2 YEARS

Child's First Name: \_\_\_\_\_ Middle Name/s: \_\_\_\_\_

Surname: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ Male:  Female:

**NAPPIES AND TOILETING:** Toilet:  Potty:  Nappies:  With help:

Are there any special words that mean toilet to your child: \_\_\_\_\_

**BOTTLES AND FEEDING:** Breast-fed:  Formula Fed:  Brand of Formula: \_\_\_\_\_

*(Please supply adequate bottles of made up or expressed milk for your child) Refrigeration and warming facilities are provided. Please inform us if you change your child's formula.)*

Is your child on cow's milk: YES  NO  If NO please specify other: \_\_\_\_\_

*(Please supply if other than Cows/Soy milk i.e. Goats or Rice)*

If your child is bottle fed how often will they need a bottle? Amount given: \_\_\_\_\_

Approx times: \_\_\_\_\_

Is your child using a cup/trainer cup: YES  NO  With milk: YES  NO

Other: \_\_\_\_\_

Is your child's feed supplemented with juice / water etc: YES  NO  \_\_\_\_\_

Can your child hold bottle independently: YES  NO  Cup: YES  NO

Is your child on solids: YES  NO  Give details: \_\_\_\_\_

Are they independent in eating: YES  NO  \_\_\_\_\_

**SLEEPING:** How often does your child need a sleep during daytime hours: \_\_\_\_\_

How long do they normally sleep: \_\_\_\_\_

Does your child need a comforter to sleep: YES  NO  Describe \_\_\_\_\_

Any other information we need to know concerning your child's sleeping patterns: \_\_\_\_\_

Does your child attend any other children's service at present: YES  NO  \_\_\_\_\_

Does your child get upset when left with other people: YES  NO  \_\_\_\_\_

**GENERAL NEEDS:** Are there any words that we need to know that have special meaning for your child?

Please translate if appropriate: \_\_\_\_\_