Infant/ Toddler

Needs and Services Plan

Childs Name _____ Nick Name _____

Date of Birth _____ Age _____

Parent's Name/ Mon _____ Dad _____

Siblings:

_____ _____

Babies Mood:

Temperament _____

_____

Self-soothing methods_____

_____

Pacifier Yes/No Special Blanket Yes/No

Special Instructions_____

_____

_____

Sleep Schedule

Does your baby sleep through the night? Yes/No

How many hours a night? _____

Is your baby on a nap schedule? Yes/No

What time does your baby nap during the day. _____

Do you want us to stay on nap schedule? Yes/No

Special Instruction _____

_____

_____

Babies First Foods

Food / Date introduced Allergies Yes/No

Peas _____

Corn _____

Carrots_____

Green Beans_____

Squash_____

Bananas_____

Peaches_____

Applesauce_____

Pears_____

Other Foods Introduced_____

_____

_____

_____

Special Feeding Instructions_____

_____

_____

_____

Diaper Instructions

Does your baby have any sensitivity to diapers? Yes/No

What brand does your baby use? _____

Feeding Schedule

Does your baby nurse or bottle feed? _____

Nursing Baby

Does your baby have a nursing schedule Yes/No

Does your baby use a bottle easily outside your care? Yes/No

Special feeding instructions _____

_____

_____

Formula

What brand formula does your baby use? _____

Allergies to any formula? Yes/No If so what brand? _____

How many ounces does your baby eat at one time? _____oz.

How many times does your baby feed a day? _____

Does your baby drink water from a bottle? Yes/No Sippy Cup? Yes/No

Does your baby drink regular milk yet? Yes/No If yes what kind? _____

Special Instructions _____

Schedule

A.M. Feedings _____-/- _____-/-_____

Afternoon Feedings _____-/-_____-/-_____

Evening _____-/-_____-/-_____

Special Instructions _____

_____

_____

Introduction to Food

Does your baby eat solid food? Yes/No

First Foods Rice? Yes/No Oatmeal? Yes/No What age introduced? _____

How many ounces? _____ Mixed with Formula or water? _____