



Infant Needs and Services Plan

Child's Name _____ DOB ___/___/___ Age _____

Date _____

This plan is completed at enrollment and updated every 3 months until the child is 2 years old. Parent/Guardian and teacher initial and date every change and update to the original plan.

Eating

Bottles/ Formula

Does your child use a bottle? Yes or No

If yes, what type of bottle/nipple? _____

What type of formula? Iron or low

How many ounces does your child usually drink in a feeding? _____

Does your child drink from a cup? Yes or No

If yes, what kind of cup/lid? _____

Solid Foods

Is your child eating solid food at this time? Yes or No

If yes, describe what types of food (type of cereal, types of baby foods or table foods)

How often and at what time of day do you feed your child solid foods?

What are your baby's regular eating habits? (Quantity of food, bottle before/after nap, etc.) _____



nap, etc.) _____

Any special nutritional fortifiers and/ or supplements required? Yes or No
 If yes, please specify: _____

Does your child have any known food allergies? Yes or No
 If yes, please specify: _____
 Please describe allergic reaction symptoms: _____

FEEDING AND FORMULA INFORMATION

Please provide us with a list of foods that your baby eats. Include the brand of formula as well as snack items, juice, water, etc. Be sure to let us know if there are foods or beverages that you do **NOT** want us to serve your baby or that your baby does not like.

Formula/Milk

Please list out formula and milk types: _____

In the section below, please put Y (Yes) or N (No) after each food or drink.
 In the section below, please put Y (Yes) or N (No) or NS (Not Sure) after each food or drink.

Liquids/Juice

Apple___ Orange___ Grape___ Pineapple___ Mixed___ Other___ Water___

Fruits

Bananas___ Apples___ Pears___ Plums___ Mixed___ Melons___ Prunes___ Apricots___
 Oranges___ Cherries___ Applesauce___ Pineapple___ Mango___ Strawberry___
 Blueberry___ Other_____

Vegetables

Carrots___ Green Beans___ Corn___ Peas___ Peas & Carrots___ Sweet Potatoes___
 Squash___ Potatoes___ Pumpkin___ Spinach___ Beets___ Broccoli___ Mixed___
 Garden___ Veggie Mix___ Pinto Beans___ Other Beans___ Other_____

Snacks

Jello___ Pudding___ Graham Crackers___ Saltines___ Other Snack Crackers___
 Pretzels___ Cereal (dry)___ Cookies___ Teething Biscuits___ Animal Crackers___
 Bread/Toasts___ Peanut Butter___ Jelly___ Ice Pops___ Other_____



Meats and Dairy

Ice Cream___ Sour Cream___ Yogurt___ Cottage Cheese___ Cheese___ Fish Sticks___
Lunch Meat___ Tuna___ Eggs___ Veal___ Chicken___ Turkey___ Beef___ Ham___
Other _____

Infant Cereal

Rice___ Barley___ Oatmeal___ Cream of Wheat___ Mixed___ Other_____

Lunch Items

Breads___ Pastas___ Top Ramen___ French Fries___ Pancakes___ Pizza___ Burritos___
Mashed Potatoes___ Rice___ Condiments___ Other_____

Are there certain foods not listed above that your baby does not eat or like?

Sleeping/Napping

How many times per day does your child nap? _____
When during the day does your child typically nap? _____
How long does your child usually nap? _____
How do you know when your child needs a nap? _____

How do you help your child sleep? (rocking, holding, bottle, etc.) _____

Any special instructions regarding your child's sleep routine? (special blanket or a pacifier for example) _____

Toileting/Diapering

Most children are not ready to begin toilet training until 2 years of age. Generally, we will not begin to toilet train a child before 2 years old unless requested by the parent/guardian and after consideration of the child's developmental readiness.

If you have begun to toilet train your child, please describe your child's progress:



Do you have any special instructions regarding your child's diapering? Yes or No
If yes, please describe: _____

Please note that parents/ guardians provide diapers/wipes and any ointments required each day.

Sleeping/Napping

Does your child require any special accommodations not covered by this plan?

Parent/ Guardian Signature: _____ Date: ___/___/___

Teacher Signature: _____ Date: ___/___/___

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Date plan reviewed/ updated: ___/___/___ Parent/ Guardian initials: ___

Teacher initials: ___ Comments: _____

Date plan reviewed/ updated: ___/___/___ Parent/ Guardian initials: ___

Teacher initials: ___ Comments: _____

Date plan reviewed/ updated: ___/___/___ Parent/ Guardian initials: ___

Teacher initials: ___ Comments: _____

INDIVIDUAL INFANT SLEEPING PLAN

Date of plan: _____

SECTION A: INFANT'S INFORMATION

Infant's Name	Gender	Birth Date
Authorized Representative's Name (Primary Contact)		Phone Number
Authorized Representative's Name (Secondary Contact)		Phone Number

SECTION B: SLEEPING ENVIRONMENT INFORMATION

At home, the infant sleeps in: <input type="checkbox"/> Crib <input type="checkbox"/> Play Yard <input type="checkbox"/> Other (Specify) _____	What are the Infant's usual sleeping hours? _____ _____
What is the infant's average length of the Infant's nap(s) during the day time? _____ minutes _____ hours	Does the infant use a pacifier? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes If yes, brand: _____

SECTION C: INFANT'S ABILITY TO ROLL

My child, _____ is able to roll from their back to their stomach and stomach to their back beginning _____ / _____ / _____.

Authorized Representative Signature	Date
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SECTION D: INFANT'S ABILITY TO ROLL IN CHILD CARE

Provider observed the infant is capable of rolling from their back to their stomach and stomach to their back.

Provider Signature	Date
Authorized Representative Signature (To be completed no later than the next business day following observation)	Date

SECTION E: MEDICAL EXEMPTION

Does the infant have a medical exemption? Yes No

If the infant has a medical exemption to sleep in a position other than on their back a licensed physician must provide instruction on an alternate sleeping position.

The following shall be included with the medical exemption:

- Instructions on how the infant shall be placed to sleep, including sleep position.
- Duration the exemption is to be in place
- The licensed physician’s contact information
- Signature of the licensed physician and date of signature

ATTACH REQUIRED DOCUMENTS TO THIS FORM AND MAINTAIN IN THE INFANT’S FILE PURSUANT TO TITLE 22, SECTION 101429(a)(2)(c) FOR CHILD CARE CENTERS OR SECTION 102425(c)(2) FOR FAMILY CHILD CARE HOMES.

I certify that all information contained in this form is complete and accurate to the best of my ability.

Authorized Representative Signature

Date