Infants Needs and Services Plan

FEEDING PLAN

Date: _____

Name of child: _____ Date of birth: _____

Home phone: _____ Work phone: _____

Food allergies: _____

What type of reaction can be expected? _____

Breast fed? ____ yes ____ no How often? _____

Bottle fed? ____ yes ____ no How often? _____

Formula: _____ Amount: _____

Holds own bottle? ____ yes ____ no Position while feeding: _____

Temperature of liquid? _____ warm _____ room temp _____ cold

solids? ____ yes ____ no _____ strained _____ junior _____ finger food

solids now in diet? _____ cereal _____ vegetables _____ meat _____ fruits

Usual amount of item eaten: _____

Temperature of foods: _____ warm _____ room temp _____ cold

Feeds self? _____ yes _____ no _____ needs help

What liquid served with meals? _____

____ bottle ____ cup _____ needs help with cup/bottle

Food likes: _____

Food parents/physicians DO NOT want child to have: _____

_____

TOILETING PLAN

Type of diapers:

_____ cloth

_____ disposable

Creams, ointments, powders:

Name: _____

Times: _____

Are bowel movements regular? _____ yes _____ no

Time? _____ Number? _____ Type: _____

Word used for movement: _____ Urination: _____

Potty training? _____ yes _____ no (Boys) _____ sit _____ stand

If boy, sit: _____ frontward _____ backward

Use potty chair? _____ yes _____ no Regular toilet? _____ yes _____ no

Needs to be reminded? _____ yes _____ no How often? _____

Needs help? _____ yes _____ no

INDIVIDUAL SLEEP PLAN

Nap schedule

Times: _____ Duration: _____

Favored sleep position: _____

Sleep problems: _____ nightmares _____ breathing difficulties

_____other, please explain: _____

Does child take to bed _____ bottle _____ pacifier

_____ favorite blanket _____ other _____

If bottle, what liquid? _____

SPECIAL NEEDS

Does your child require any special attention/assistance?_____

Please explain:_____

_____

_____

Comments:

_____ _____

Parent Signature Date

_____ _____

Teacher Signature Date