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Alpine Children's Academy

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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