Tamarak LLC: Hayden ELC
Infant Care Plan

Child's name: _____ Age: _____ Enrollment Date: _____

Eating Habits:

Does the child use: (circle one) Breast milk -or- Formula

Will you breastfeed at the facility?(circle one) Yes -or- No

If so, what times? _____

(We have a rocking chair in the classroom that breast feeding moms can use anytime they want to breast feed their child)

If using formula, which brand and type: _____

What type of bottles will you supply? _____

Please remember, you will need to bring clean bottles for each feeding daily, we do not clean and sanitize bottles at our center, we only rinse them after use.

Please inform us about your child's feeding schedule: *If your child is on breast milk, please provide it in a freezable zip lock pouch/bag that is clearly labeled with your child's name, date pumped, and how many ounces. Please provide a separate bag with the number of ounces per feeding.*

Time of day: _____ Ounces to provide: _____

Time of day: _____ Ounces to provide: _____

Time of day: _____ Ounces to provide: _____

Time of day: _____ Ounces to provide: _____

Time of day: _____ Ounces to provide: _____

Have you introduced any solid food yet? (circle one) Yes -or- No

If so, what solid foods has your child eaten and what times does your child eat?

_____

_____

Diapering Habits:

What type of diaper does your child use? (circle one) Cloth -or- Disposable

(If cloth diapers are provided, you must provide a sealable pouch for used diapers to be placed in. You will take them home daily and provide us with a clean bag daily. By state regulations, we cannot dump or rinse cloth diapers.)

Is your child prone to diaper rash? (circle one) Yes -or- No

What type of ointment will you provide for diaper rash? _____

How often would you like it to be applied? _____

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Any other information we should know about your child's diapering routine?

_____

_____

Sleeping Habits:

What is your child's sleep schedule?

Time of day: _____ How long does the child sleep? _____

Time of day: _____ How long does the child sleep? _____

Time of day: _____ How long does the child sleep? _____

Time of day: _____ How long does the child sleep? _____

Is your child an independent sleeper? (sleeps alone in crib) Yes -or- No

Describe your child's sleep routine?

_____

_____

What are the signs your child is sleepy? _____

What helps your child fall asleep?

_____

_____

Calming/Soothing Habits:

What is the most effective way to calm/sooth your child when fussy or crying?

_____

_____

Are there any specific items that help calm your child? (pacifier, blanket, song, toy, etc.)

_____

_____

Teething Habits:

Is your child teething? (circle one) Yes -or- No

When your child is teething, will you provide teething medication? (circle one) Yes -or- No

Parent Signature: _____ Date: _____

Infant Teacher Signature: _____ Date: _____

Director Signature: _____ Date: _____