Santa Rosa Rise and Shine Child Care Center

INFANT NEEDS & SERVICES PLAN

Child's Name: ____________________________ Date of Birth: ________________________

Nickname (if any) _________________________ Date Completed: _____________________

This plan is completed at the time of enrollment and updated every 3 months or when changes are reported by parent(s), until the child is 18 months of age. Parent/guardian and teacher initial and date every change and update to the original plan.

SLEEPING:

SRRS Children's center policy requires that infants under 12 months of age must be placed on their backs to sleep (to reduce the risk of SIDS). If a child has a medical condition requiring the child to sleep in an alternate position, a signed physician's note is required. Infants are placed in sleep sacks for warmth. Blankets, soft animals, pillows, or other objects are not allowed in infant cribs.

What time does your child wake up in the morning? ______; nap in the morning? ______ and how long ______; nap in afternoon? ______ and how long _____; goes to bed at night?_______.
How do you know your child is tired? ____
Does your child sleep: alone? (Y)___ (N)___; with parents? (Y)___ (N)___
Does your child: sleep lightly? (Y)___ (N)___; when it's quiet? (Y)___ (N)___; when it's noisy? (Y)___ (N)___;
Does your child fall asleep: on own? (Y)___ (N)___; being rocked? (Y)___ (N)___; with pacifier? (Y)___ (N)___;
when you lay with child? (Y)___ (N)___; being breast/bottle fed? (Y)___ (N)___; with music? (Y)___ (N)___;
having back rubbed/patted? (Y)___ (N)___; Other____
Do you have any concerns about your child's sleep habits? (Y)___ (N)___; If yes, please specify. ___________
____

EATING:

Does your child have any known food allergies? (Y)___ (N)___; If yes, list allergies here: _________________
____

***A *Medical Statement to Request Special Meals or Accommodations* form must be completed by a physician for any known food allergies or special meal needs.**

Liquids:

Child is to be fed the following:

- ☐ Breast Milk
- ☐ Formula (List Brand) ____
- ☐ Whole Milk (12 months or older)
- ☐ Whole Milk – Lactaid (12 months or older)

Child receives liquids from:

- ☐ Breast only. Plans during school? ______________________________________
- ☐ Bottle (List type of bottle/nipple) ______________________________________
- ☐ Cup (List cup/lid type) ____

What is your child's feeding schedule? (On demand or scheduled? If scheduled, please give details.) _________
____
How many ounces does your child usually eat at a feeding? ______________________________
What needs does your child have during their feeding: (ex. Needs to always be burped, sit up after feeding, etc.)
____

Solid Foods:

Foods will only be fed at the center after they have been introduced at home and tolerated by the child.

Does your child currently eat solid foods? (Y)___ (N)___; If yes, how often and at what time of day do you feed your child solids?____

Can your child: feed self? (Y)___ (N)___; eat in a high chair? ((Y)___ (N)___; sit at the table? (Y)___ (N)___

Child Eats Using:

- ☐ Assistance from adult
- ☐ Hands
- ☐ Spoon
- ☐ Fork
- ☐ Chopsticks
- ☐ Special Utensils (please list)____

Foods child has been introduced to at home:

Dairy:

Breast Milk (Y)___ (N)___ Formula (Y)___ (N)___; If yes, list brands_________________________

Eggs(Y)___ (N)___ Cheese (Y)___ (N)___ Yogurt (Y)___ (N)___

Vegetables:

Beets (Y)___ (N)___ Broccoli (Y)___ (N)___ Carrots (Y)____ (N)____

Cauliflower (Y)___ (N)___ Corn (Y)___ (N)___ Green Beans (Y)___ (N)___

Peas (Y)___ (N)___ Peppers (Y)___ (N)___ Potatoes (Y)___ (N)___

Squash (Y)___ (N)___ Sweet Potatoes (Y)___ (N)___ Tomato (Y)___ (N)___

Fruit:

Apple (Y)___ (N)___ Bananas ((Y)___ (N)___ Cantaloupe (Y)___ (N)___

Honey Dew (Y)___ (N)___ Oranges (Y)___ (N)___ Peaches (Y)___ (N)___

Pears (Y)____ (N)____ Pineapple (Y)___ (N)___ Plums/Prunes (Y)___ (N)___

Strawberries (Y)___ (N)___ Watermelon (Y)___ (N)___

Fruit Juice (Y)___ (N)___; If yes, list types ______________________________________

Grains:

Barley Cereal (Y)___ (N)___ Rice Cereal (Y)___ (N)___ Mixed Grain Cereal (Y)___ (N)___

Oatmeal Cereal (Y)___ (N)___ Wheat Cereal (Y)___ (N)___ Cheerios (Y)___ (N)___

Corn Flakes (Y)___ (N)___ Crackers (Y)___ (N)___ Wheat Bread (Y)___ (N)___

Tortillas (Y)___ (N)___ Rice (Y)___ (N)___ Pasta (Y)___ (N)___

Proteins:

Chicken (Y)___ (N)___ Turkey (Y)___ (N)___ Pork (Y)___ (N)___

Fish (Y)___ (N)___ Beef (Y)___ (N)___

Beans (Y)___ (N)___; If yes, list types____

For Children 12 months or older:

Whole milk (Y)____ (N)____, Honey (Y)___ (N)___; Peanut Butter (Y)___ (N)___;

Other Nut Butters (Y)___ (N)___; if yes, list types ________________________________

What are some of your child's favorite foods including foods from your home/culture? _______________

____

(For health and safety reasons children will not be allowed to lie down or walk around with a bottle or cup.)

DIAPERING:

Parents are required to provide diapers, wipes and any ointment required each day.

Does your child have an allergy to any types of diapers/wipes? (Y)___ (N)___; If yes, provide brand name(s):

____

Type Diapers to be Used:

- ☐ Disposable (List type/brand) ____
- ☐ Cloth (Cloth diapers will be bagged only.)

Are bowel movements regular? (Y)___ (N)___; please explain. _________________________________

What words/phrase do you use for bowel movements? ____________________ Urine? ___________________
Are there any specific creams or ointments to be used at diaper change time? (Y)___ (N)___; If yes, list brand and provide instructions for use:____
Please list any special routines, rituals, songs, etc. that accompany diaper changes at home. ____
Other Instructions/Concerns:____
____

PRENATAL & POSTNATAL HEALTH:

Did you have any illnesses or take any medications during pregnancy? (Y)___ (N)___; If yes, specify _________
____
Were there any complications with pregnancy/delivery? (Y)___ (N)___; If yes, specify _____________________
____
Were you full term? (Y)___ (N)___; If no, how many weeks early? ___________________________________
Were there any complications after birth? (Y)___ (N)___; If yes, specify ____________________________
____
Is/has your child been exposed to secondhand smoke of any kind? (Y)___ (N)___
Does your child have a disability/chronic health condition that has been diagnosed? (Y)___ (N)___; If yes, specify
____
Is/has your child been under regular supervision of a Physician? (Y)___ (N)___; If yes, specify date of last exam
____
Does your child have any health or teeth problems? (Y)___ (N)___; If yes, specify: _______________________
Is your child taking any prescribed medication(s) regularly? (Y)___ (N)___; If yes, please list: ______________
____(***Form required if needed during care hours**)
Does your child have a chronic health condition or specific health need? (Y)___ (N)___; If yes, specify________
____
Has your child had any serious or severe illnesses, surgeries, hospitalizations or accidents? (Y)___ (N)___; If yes, specify including dates ____
Does your child have frequent, ear infections? (Y)___ (N)___; Colds? (Y)___ (N)___; Diarrhea? (Y)___ (N)___;
What age did your child begin crawling? ____________; walking? _____________; talking? _______________.

FAMILY INFORMATION:

The child's parents are:

- ☐ Married/Live together
- ☐ Divorced
- ☐ Separated
- ☐ Widowed

Child lives with: (check all that apply)

- ☐ Both Parents
- ☐ Mother only
- ☐ Father only
- ☐ Legal Guardian
- ☐ Mother & partner
- ☐ Father & partner
- ☐ Mother & Father share custody (Schedule) ____
- ☐ Siblings (Name(s)/Ages)____
- ☐ Grandparents
- ☐ Other Relatives (Relationship to child) ____
- ☐ Unrelated roommates
- ☐ Other (specify)____

What languages are spoken in the home(s)?____
What is your family's cultural identification (values, traditions)? _________________________________
____

SOCIAL/EMOTIONAL DEVELOPMENT:

Has your child ever been in group care? (Y)___ (N)___; If yes, where? ________________________________,
how long? ________________, and how does your child respond in group situations? _____________________
What can we do to help your child adjust to child care? ____

How would your describe your child's temperament? ___
How does your child communicate his/her needs? ___
How do you comfort your child? ___
List special comfort item(s) your child uses: (such as blanket, stuffed animal, doll)? ___
Does your child have any fears? Yes ____ No ____ If yes, specify.___
Does your child enjoy playing alone or with others? (Y)___ (N)___

PHYSICAL AND MOTOR DEVELOPMENT:

What are some things your child likes to do indoors? ___

What are some things your child likes to do outdoors? ___

Do you have any concerns about your child's physical/motor development? (Y)___ (N)___; If yes, please explain

COGNITIVE DEVELOPMENT:

Does your child enjoy messy play? (Y)___ (N)___; If yes, specify types of messy play ___

What are some examples of some words your child uses? ___

What kind of music (songs) does your child respond to? ___

What is your child's favorite thing to do when you are together? ___

Check any areas you have concerns about your child's development… (Please explain)
___ Hearing &/or Vision ___
___ Speech & Language Development ___
___ Ability to move ___
___ Ability to relate to others ___
___ Overall Development ___

Parent's Signature ___ Date___
Caregiver's Signature ___ Date ___

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