The Bay Kids, LLC

12990 Monticello Dr
Mail to: PO Box 2179
Lusby, MD 20657
410-231-2131

MSDE-OCC License No. 250638

Individual Personal Care Plan

for

Infants and Toddlers

Updated
March 2023

David C Houghton

The Bay Kids, LLC
Childcare and Early Learning Center
12990 Monticello Drive
Mail to: PO Box 2179
Lusby, MD 20657
Main: 410-231-2131

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Families Since 2015

Origination Date: Tuesday, March 14, 2023
Last Modified Date: Tuesday, March 14, 2023

Individual Personal Care Plan for Infants and Toddlers

Child's Name:_____ Parent Name: _____

Date of Birth: _____

Age:_____

Bottle/Cup

Check Preference: ☐ **Bottle** ☐ **Cup**

Routine

Breast Milk	Amount	Time(s) of Day Requested

Formula	Brand	Amount	Time(s) of Day Requested

Milk	Type	Amount	Time(s) of Day Requested

Juice	Type/Brand	Amount	Time(s) of Day Requested

Introducing Solid Foods

We are recommending introducing infant cere at 4 – 6 months; vegetables, fruits, and juices at 5-7 months; protein such as cheese, yogurt, cooked beans, meat, fish, chicken, and egg yolks at 6-8 months; whole eggs at 10-12 months; milk at 12 months. We can introduce the use of a cup and spoon at 8-10 months.
If you do not wish to follow our recommendations, please comment on your preferences, then sign below.

Comment: .....

.....

.....

Print Name _____Signature_____ Date _____

Eating Routine

Any food allergies?_____

_____

Solid Food: _____ Time of day you want given: _____

Food likes and eating preferences: _____

_____

Food dislikes or eating problems: _____

_____

Special diet/requests: _____

_____

Child eats ☐ On Lap ☐ High Chair ☐ Other_____

Child eats with ☐ Spoon ☐ Fork ☐ Hands ☐ Other _____

Toilet/Diapering Habits

Does your child have frequent diaper rash?

Do you use ☐ Oil ☐ Powder ☐ Lotion ☐ Other _____

Does child wear ☐ Disposable Diapers ☐ Cloth Diapers

Are bowel movements ☐ Regular ☐ Irregular How Often:_____

Is there a problem with ☐ Diarrhea ☐ Constipation

Is your child toilet trained? ☐ Urination ☐ Bowels

What is used at home? ☐ Potty Chair ☐ Special Seat ☐ Regular Seat

Word used for urination:_____ for bowel movement: _____

Does your child have accidents? ☐ No ☐ Sometimes ☐ Often ☐ No

Comforting/Distress

Does your child have a security object? ☐ Yes ☐ No ☐ Name: _____

Does your child use a Pacifier? ☐ When _____

Other information: _____

_____

What comforting objects would you like your child to have at the program? _____

_____

Sleeping Routine

Does child sleep in: ☐ Crib ☐ Bed ☐ Family Bed ☐ Other _____

Pre- nap Routines/Rituals:

How many naps per typical day? Morning from: _____ to _____

Afternoon from _____ to _____

Evening from _____ to _____

Typical length of nap: _____

In what position does your child prefer to nap? _____

Waking behavior/routine _____

_____

Special concerns: _____

_____

What time does child go to bed at night? _____

What time does your child wake in the morning? _____

Are there any sleep time rituals? _____

_____

Separation

Has your child been in the care of someone other than yourself? ☐ Yes ☐ no

If so, with whom? _____

_____

What difficulty does your child experience separating form you? _____

_____

What are some ways to calm your child? _____

_____

What are your feelings about leaving your child in our care? _____

_____

How can we help you feel more comfortable and involved in the care of your child? _____

_____

_____

Social Relationships

Has your child had any experiences playing with other children? _____

_____

Would you characterize your child as often

☐ Friendly ☐ Aggressive ☐ Withdrawn ☐ Shy ☐ Other

Reactions to strangers?

☐ Friendly ☐ Aggressive ☐ Withdrawn ☐ Shy ☐ Other

Have you had any previous childcare experience/other providers? _____

_____

If so, did it meet your needs and expectations? ☐ Yes ☐ No

Explain:_____

_____

Does your child prefer to play: ☐ Alone ☐ In small groups

Favorite toy and activities? _____

Is your child frightened by: ☐ Animals ☐ Rough Kids ☐ Loud Noise ☐ Dark Rooms ☐ Other

explain: _____

What is your child style of guidance and discipline? _____

_____

_____

Daily Schedule

Using approximate times, please generally describe your child's current daily activities such as awakening, eating, time out of crib, napping, toilet habits, fussy time, evening bedtime, etc.

Morning _____

_____

_____

Afternoon _____
_____

Evening _____
_____
_____

What do you, as a family, hope to get out of this childcare experience? _____
_____
_____
_____

We will update the personal care plan every 3 months, or sooner if requested by a parent/guardian or as needed by the staff.

Parent signature: _____ Date: _____

Staff signature _____ Date: _____

Date of change _____ Parent Initials _____Staff Initials _____

Thank you,

_____
Shannon N. O'Steen, Director

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