INFANT PERSONAL CARE PLAN DEVELOPMENTAL HISTORY FORM

Today's Date: ____________________ Date of Enrollment/Transition: ____________________

Child's Name: ____________________ Date of Birth: ______________ Age: ______________

Date of Last Physical (for WA State only): ____________________

What would you like us to call your child?:____________________

Parent/Guardian Name: ____________________

Parent/Guardian Name: ____________________

Name of Person Completing Form: ____________________

Primary Caregiver: ____________________

Classroom: ____________________

FAMILY INFORMATION

In the columns below list the names of family members residing with the child. Please include siblings, extended relatives, and pets. For each person listed provide the name the child uses to address that individual and include ages of siblings.

Name	How child addresses this individual?	Age

Please list the words used in your language corresponding to the words in English. Include additional words in the blank columns if needed.

I'll take good care of you	
I see that you are crying	
Let's change your diaper	
I like your smile	
It's time for your bottle	
Time to eat	
Time for your nap	
Mommy will be back	
Daddy will be back	

If parental custody is shared, describe the custody arrangements: ____________________

Please tell us about cultural family customs, rituals, or traditions that will help us make your child's experience more meaningful, including languages spoken at home: ____________________

Infant Personal Care Plan - Developmental History Form

CHILD'S NAME: ______________________________

DEVELOPMENTAL HISTORY

Age Child Began: Sitting: ________ Crawling: ______ Standing: _______ Walking with support: ________

Walking independently: ________________ Cooing: _________________ Babbling: ____________________

Saying audible words:_____________________ Saying 2 or 3 simple sentences: ______________________

Do you have developmental concerns about your child? ______________________________

How does your child communicate his/her needs? ______________________________

CHILD'S HEALTH

List medications regularly taken and conditions requiring them: ______________________________

Describe serious illnesses or hospitalizations: ______________________________

Describe special physical conditions, disabilities, allergies, or concerns: ______________________________

Does your child have a special need?______________________________

Explain special services and accommodations, which are different from those provided by the center's routine program (i.e. exercises, equipment, materials, or special services personnel): ______

Note: For documented medical allergies an Allergy Health Care Plan completed by the child's medical provider is required.

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CHILD'S NAME: ______________________________

NUTRITION PRACTICES AND ROUTINES

How is your child fed? Check all that apply: Breast: ☐ Bottle: ☐ Cup: ☐

In the corresponding row, provide your child's feeding details.

	Brand	Amount	Preferred time of day given
Formula/Milk			
Breast Milk			
Juice			

If your baby is exclusively breast fed, please outline your daily plan: ______________________________

If your baby is breast fed or receiving expressed breast milk, how can we support you? ______________________________

List special dietary requests, and restrictions: ______________________________

Have solid foods been introduced? Yes ☐ No ☐ If yes, please identify: ______________________________

Food likes and eating preferences: ______________________________

Child Eats With: Spoon: ☐ Fork: ☐ Fingers: ☐

Child is Fed in: Highchair: ☐ In Arms: ☐ Bouncy Seat: ☐ Other: ______________________________

Preferred time of day to feed child: ☐ A.M. ☐ A.M. ☐ P.M. ☐ P.M.

Additional Information: ______________________________

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CHILD'S NAME: ______________________________

SLEEPING ROUTINES

Pre-nap routines/rituals: ______________________________

____

____

____

Number of naps daily: ___ **From:** ______ **To:** ______ **From:** _____ **To:** _____ **From:** _____ **To:** ______

Preferred sleep position*: ______________________________

At home child sleeps in (Check all that apply: Bassinet: ☐ Crib: ☐ Bed: ☐

Child's typical waking behavior/routine: ______________________________

____

____

Special sleeping concerns: ______________________________

____

____

Note: Bright Horizons places infants to sleep on their backs in crib unless a waiver has been signed by the parents and the child's physician, stating that the child should be placed in a position other than on his/her back and if allowed by the state licensing agency. Following the recommendation of the American Academy of Pediatrics, soft items such as bumpers, stuffed animals (including pacifiers with a stuffed animal attached), blankets and quilts are not allowed in cribs. The use of sleep or swaddle sacks are recommended for naptime; however, there may be restrictions on the use of and type of these by the state licensing agency.

COMFORTING CHILD

Position child prefers to be held: ______________________________

Security object (if any):__________________ Name child uses for object/when needed: ____________

____

____

Does your child use a pacifier? Yes ☐ No ☐ If yes, when: ______________________________

Describe how adults can comfort your child? ______________________________

____

____

DIAPERING/TOILETING ROUTINES

Please check which type of diapers you will provide: disposable: ☐ cloth: ☐

Words used for urination: ______________________________

Words used for bowel movement: ______________________________

____

____

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CHILD'S NAME: ______________________________

SOCIAL RELATIONSHIPS

Has your child had any experience with group care? If yes, please describe: ______________________________

How does your child react to new situations and new children and adults? ______________________________

Has your child had previous child care experience? If yes, explain how it met, or did not meet, your expectations? ______________________________

Child's favorite toys and activities: ______________________________

Does your child have any fears? Explain: ______________________________

ADDITIONAL PERTINENT INFORMATION

To help us care for your child as an individual, please explain your parenting philosophy: ______________________________

Is there additional information you feel is important for the staff to know about your child or family? ______________________________

What do you as a family, hope to get out of this child care experience? ______________________________

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CHILD'S NAME: ______________________________

Sections of this Personal Care Plan will be updated every 3 months or sooner if requested by a parent/guardian.

Parent/Guardian Signature: ____________________ Date: ____________________

Staff Signature: ____________________ Date: ____________________

Date of Change:		Parent Initials:		Staff Initials:	
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