INFANT SERVICE PLAN
2024-2025

WILD ROOTS
HOLISTIC LEARNING CENTER

Student Name: _____ Date of Birth: _____
Parent Name(s): _____
Number of Siblings and Ages: _____
Baby delivered at _____ weeks
Were there any complications with the pregnancy or delivery which would be important for us to know about?

_____

_____

Feeding:

Liquids:

What does your child drink at home?

☐ **Breastfed:** Has your child ever taken a bottle? ☐ Yes ☐ No

☐ **Bottle-fed:** ☐ Breastmilk ☐ Formula *Type of formula:* _____

☐ Juice ☐ Water

Any problems or concerns with breastfeeding/bottle feeding that would be helpful for us to know about?

_____

_____

Feeding patterns or schedule:

_____

_____

Approximately how many ounces for each feeding: _____

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Solids:

Is your child eating solid foods? ☐ Yes ☐ No

If yes, how old did you introduce your child to solids? _____

Some foods your child currently *likes:*

_____

_____

Some foods your child currently *dislikes:*

_____

_____

***Please inform your teacher when you have given a new food and please do not bring the new food to the center until you have tried it at home for at least four days.**

What does your child use?

☐ Bottle ☐ Cup ☐ Spoon ☐ Highchair

List all food allergies, food sensitivities, or feeding issues:

_____

_____

Any special instructions from your child's pediatrician relating to his or her diet?

_____

_____

Diapering:

How many wet diapers does your child generally have in a day? _____

How many solid diapers? _____

Type/brand of diapers used & current size: _____

Type/brand of wipes used: _____

Any digestive/elimination problems or concerns that we should be aware of?

_____

_____

Is your child prone to infections or rashes? _____

If so, type of cream/ointment do you regularly use: _____

***Please note that you will need to complete and sign a permission form prior to dropping off any type of cream (including over the counter creams and ointments).**

Sleeping:

What is your child's current nighttime sleeping schedule?

_____

_____

What is your child's current day time sleeping schedule?

_____

_____

How does your child fall asleep?

_____

_____

Does your child use any comforting items for sleeping (pacifiers, blanket etc.)

_____

Can you tell us anything about your child's sleeping habits that might be helpful?

_____

_____

Development:

Developmental Milestones	Age	Any Concerns?
Makes eye contact (tracks objects)		
Smiles and laughs		
Makes verbal sounds (babbling)		
Holds head up		
Grasps objects		
Responds to loud noises		
Rolls over		
Sits		
Reaches for objects		
Crawls		
Stands with support		
Mimics words		
Uses gestures for communication (nods head, points, etc.)		
Cruises (walks while holding onto furniture)		
Walks		

Medical Information:

Does your child have any special needs?

_____

Does your child have any immediate health concerns that we should be aware of that may require extra care or attention?

_____

_____

Has your child had any medical concerns? If so please explain in detail. Please note that a doctor's note may be required to ensure that we are capable of meeting specific health needs.

_____
_____
_____

Medical history that would be helpful for us to be aware of (hospitalizations, surgeries, serious infections etc.)

_____

_____

Any known allergies: _____

Family history of severe allergies: _____

Is there any other information you would like us to know about your child so we may give him/her the best possible care?

_____

_____

_____

Please sign below:

Parent's/Guardian's Signature: _____ **Date:** _____