INFANT SERVICE PLAN 2024-2025



Student Name:	Date of Birth:
Parent Name(s):	
Number of Siblings and Ages:	
Baby delivered at weeks	
Were there any complications with th	e 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: Breastmi	ilk Formula <i>Type of formula:</i>
☐ Juice ☐ Water	
Any problems or concerns with breas	tfeeding/bottle feeding that would be helpful for us to know about
Feeding patterns or schedule:	
Approximately how many ounces for	each feeding:



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 extr

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 (hospit etc.)	talizations, surgeries, serious infections		
Any known allergies:			
Family history of severe allergies:			
Is there any other information you would like us to know about yo best possible care?	our child so we may give him/her the		
Please sign below:			
	Dato		
Parent's/Guardian's Signature:	Date:		