# INFANT SERVICE PLAN
# 2025-2026

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?**

_____

_____

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## 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:** _____