INFANT/TODDLER NEEDS AND SERVICE PLAN

Child's name: ____

Date of birth: ____

Enrollment date: ______________________________________

FEEDING PLAN:

Breastfed or formula: ____

Amount____________________

Feeding Schedule____

Does child eat solid foods? Y___N___

Consistency of food?____

Schedule for introduction of solid and/or new food____________________________

Favorite foods____

Disliked foods____

Allergies____

Does child use cup/utensils?____

Does child feed him/herself? ____

Schedule for introduction of cup/utensils____________________________________

Current meal times: B__________L__________Snack__________D__________

TOILET TRAINING PLAN:

Is child in diapers? Y____N____

Have you been potty training? Y____N____

What method would you like used to potty train?

Word used for urination?______________________

Word used for defecation?_____________________

What date would you like training to start? ________________

SLEEPING:

Child usually goes to bed at ____________________________

Child usually awakes at_________________________________

Does child nap during the day? Y___N___

Time of nap____

How long does child usually sleep? ______________________

1st Review Date___________ Parent______________ Director ________________

2nd Review Date___________ Parent _____________ Director ________________

3rd Review Date___________ Parent _____________ Director ________________

4th Review Date___________ Parent _____________ Director ________________