INFANT NEEDS AND SERVICE PLAN

CHILD'S NAME _____ DATE _____/_____/_____

AGE _____ MONTHS OLD DATE OF BIRTH _____/ _____/ _____

CHILD ATTENDS (CHECK ALL THAT APPLY) ☐ M ☐ T ☐ W ☐ TH ☐ F

ESTIMATED DROP OFF TIME ____:____. ESTIMATED PICK UP TIME ____:__

FEEDING PLAN

WHICH IS YOUR CHILD USING? (CHECK ALL THAT APPLY)

☐ FORMULA ☐ BREAST MILK ☐ WHOLE MILK ☐ SOY MILK ☐ OTHER _____

IF FORMULA, WHICH BRAND? _____HOW MANY OUNCES PER FEEDING?_____

HOW OFTEN IS BABY FED? _____

DO YOU PLAN TO COME TO CAMPUS TO SERVE ANY FEEDINGS YOURSELF? YES / NO

IF YES, WHICH DAYS AND WHAT TIME?_____

MY CHILD EATS BREAKFAST AT: _____:_____ OR NOT APPLICABLE ☐

MY CHILD EATS LUNCH AT: _____:_____ OR NOT APPLICABLE ☐

MY CHILD EATS DINNER AT: _____:_____ OR NOT APPLICABLE ☐

MY CHILD EATS SNACKS AT: _____:_____ AND _____:_____ AND _____:_____ OR NOT APPLICABLE

AFTER MY CHILD'S FIRST BIRTHDAY. HE/SHE MAY EAT THE AGE APPROPRIATE SNACKS SERVED BY THE STAFF AT 9:00AM AND 2:15PM DAILY. _____ (INITIAL)

WHEN DO YOU PLAN TO INTRODUCE

SOLID FOODS? (CIRCLE ONE) 6 MO☐8 MO☐10 MO☐12 MO☐OTHER _____

SIPPY CUPS? (CIRCLE ONE) 6 MO☐8 MO☐10 MO☐12 MO☐OTHER _____

100% FRUIT JUICE? (CIRCLE ONE) 6 MO☐8 MO☐10 MO☐12 MO☐OTHER _____

I UNDERSTAND THAT ADDITIONAL FEEDINGS/PORTIONS MAY BE OFFERED TO MY CHILD AT TIMES OTHER THAN PLANNED TO ENSURE THAT MY GROWING CHILD IS NOT HUNGRY. HOWEVER, ANY MAJOR CHANGES TO THE FEEDING PLAN WILL BE DISCUSSED WITH ME BEFORE A CHANGE IS IMPLEMENTED. _____ (INITIAL)

PLEASE DESCRIBE ANY ADDITIONAL FEEDING INSTRUCTIONS._____

_____

_____

SLEEP ROUTINE

DESCRIBE YOUR BABY'S SLEEPING PATTERN.

_____

_____

SPECIAL INSTRUCTIONS FOR PUTTING BABY TO SLEEP (I.E. ROCKING, PACIFIER, STORY, SONG ETC.)

_____

_____

OTHER

AFTER REVIEWING OUR DIAPERING PROCEDURE, ARE THERE ANY ADDITIONAL INSTRUCTIONS FOR YOUR BABY?_____

_____

ARE THERE ANY HEALTH OR DEVELOPMENTAL CONCERNS THE STAFF NEEDS TO BE AWARE OF? YES / NO
IF YES, WHAT SPECIAL CARE ROUTINE NEEDS TO BE FOLLOWED?

_____

_____

ARE THERE ANY CULTURE/FAMILY SPECIFIC CHILD REARING PRACTICES WE SHOULD PLAN FOR? PLEASE EXPLAIN.

_____

_____

_____

OTHER SPECIAL INSTRUCTIONS:

_____

_____

GROOMING RELEASE

I GIVE PERMISSION FOR THE STAFF TO:

BATHE MY BABY WHEN NECESSARY. YES/NO _____ (INITIAL)

CLIP HIS/HER NAILS WHEN NECESSARY TO PROTECT HIM/HER AND OTHERS. YES/NO _____(INITIAL)

SUCTION HIS/HER NOSE WHEN NECESSARY. YES/NO _____ (INITIAL)

OTHER: _____ _____ (INITIAL)

AMENDMENTS TO THE PLAN (PLEASE INITIAL EACH ONE)

_____

_____

_____

MEDICATIONS: PLEASE FILL OUT FORM LIC 9221(PARENT CONSENT FOR ADMINISTRATION OF MEDICATIONS AND MEDICATION CHART) PER LICENSING REQUIREMENTS.

PREPARED BY:

_____	_____	DATE___/___/___
CHILD'S AUTHORIZED REPRESENTATIVE (PRINT)	CHILD'S AUTHORIZED REPRESENTATIVE (SIGNATURE)	
_____	_____	DATE ___/___/___
LYRICAL CITY PRESCHOOL STAFF MEMBER (PRINT)	LYRICAL CITY PRESCHOOL STAFF MEMBER (SIGNATURE)	

NEXT REVIEW PLANNED FOR _____/_____/_____ (APPROX. 3 MONTHS FROM TODAY)