



# Nelly's Childcare & Pre-School

## Infant/Toddler Needs and Service Plan

Child's Name:	Date of Birth:
Parent's Name:	Today's date:

**Please circle or write your answer to the following question.**

1. Is your child on a special diet? Yes/No If yes, what diet? _____ _____	6. Does your child take a bottle? Yes/No During the day _____ at night _____ What do you put in the bottle? _____ What types of nipples are used at home? _____
2. Is your child allergic to any foods? Yes/No If yes, which ones? _____ _____	7. How many meals does your child eat each day? _____
3. Are there any foods your child should not eat for medical, religious, or personal reasons? Yes/No If yes, what? _____ _____	8. How many times a day does your child eat a snack? _____
4. Has there been a big change in your child's appetite in the last months? Yes/No If yes, what? _____ _____	9. Special Likes and Dislikes? _____ _____ _____ _____ _____
5. Does your child ever eat things like plaster, dirt, clay, or paint chips? Yes/No If yes, what? _____ _____	

### Feeding Information

	Meal	Type	How Much	How Often
Breastmilk	B L D S			
Formula	B L D S			
Infant Cereal	B L D S			
Strained Vegetables	B L D S			
Strained Fruits	B L D S			
Strained meats & Proteins	B L D S			
Dairy Products	B L D S			
Juices/Water	B L D S			
Table Foods	B L D S			
Others	B L D S			

**My child uses a:**    Bottle    Cup    Fork    Spoon

### Solid Foods

Child is currently on solid foods? Yes/No

Child can feed self? Yes/No

What age (if not currently) did you begin to introduce solid foods? \_\_\_\_\_

What time of the day do you usually offer your child solid foods? \_\_\_\_\_

**Sleeping Information**

What are your child's sleeping patters?

\_\_\_\_\_

\_\_\_\_\_

Does your child sleep with any transitional objects (blankets, pacifiers, etc)? Yes/No

If yes, what objects? \_\_\_\_\_

**Toileting Information**

How many wet diapers a day? \_\_\_\_\_ How often does your child have a bowel movement? \_\_\_\_\_

When? \_\_\_\_\_ Any changes in urine or stool? \_\_\_\_\_

Explain: \_\_\_\_\_

Has use of toilet been introduced at home? Yes/No if so, how? \_\_\_\_\_

\_\_\_\_\_

Does your child have any fears or concerns regarding toileting? \_\_\_\_\_

Do you wish your child to use disposable diapers or training pants? \_\_\_\_\_

Method of toilet training: \_\_\_\_\_

\_\_\_\_\_

At what age would you like to start the introduction to toilet training? \_\_\_\_\_

**Schedule for**

Solids and New Foods:
Toilet Training:

**This form is required to be updated every three (3) months as your child's needs change and reviewed with parent/guardian prior to being signed and approved by persons listed below.**

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Teacher's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Director's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_