FIRST BAPTIST christian schools

Early Education Department

Infant & Toddler Needs & Services Plan

Please fill out and sign this form for your child ages 0 to 24 months.
It will help us get to know your child better and meet their individual needs. Thank you!

Child's Name:_____ Date of Birth: _____

Child's General Mood: Are they mostly Happy, Fussy, Colicky, etc.?_____

Has child stayed with anyone else besides parents: If so, who?

Is child Bottle or Breast-fed? □ Yes □ No

If using both, when do you use bottle vs. breast? _____

How do you give bottle? Room Temp, Warmed, Cold?_____

If you warm the bottle, what procedure do you use to warm the bottle? _____

Does the child hold his or her own bottle? □ Yes □ No

Is child on formula or milk? □ Yes □ No What kind of milk/formula do you use? _____

Is child on baby cereal? □ Yes □ No List the kinds you use:_____

Is child on strained or other baby foods? □ Yes □ No List the varieties you use: _____

Food likes: _____ Food Dislikes: _____

List amounts of food, types of food and times your child usually eats below:

Breakfast: _____

_____

Lunch:_____

_____

Snack: _____

_____

Will your child have a Bottle or be Breast-fed before arriving? _____

Will your child need breakfast? □ Yes □ No

Does your child use a pacifier? □ Yes □ No When? _____

Does your child need a special comfort item to sleep? □ Yes □ No What is it? _____

Does your child sleep through the night? □ Yes □ No

If not, how often do they wake and what do you do when they wake? Feed, Rock, Change, etc.? _____

_____

When does your child wake in the morning? _____

When does your child nap in the morning? _____ Afternoon?_____

Were there any complications during labor or delivery of your child? □ Yes □ No

Birth Weight:_____ Full Term or Weeks: _____

Any special needs or delays? _____

_____

Concerns about child health or behavior? _____

_____

Please list any other important information or special instructions on the care of your child below:

_____

_____

For Families of Toddlers:

Is your child currently potty training? □ Yes □ No

If yes, does your child use cloth underwear or pull-ups?_____

How often do you take your child to the bathroom?

Does your child request to go to the bathroom without prompting? □ Yes □ No

Does your child stay dry during hours of sleep? □ Yes □ No

Parent Name (print):_____

Parent Signature: _____ Date:_____

Relationship to Child: _____