FBCS INDIVIDUAL SLEEP PLAN

FOR CHILDREN 12 MONTHS & YOUNGER

Lic. #393615199 LiC. #393601254

Child's name: _____ **Birthdate:** _____/_____/_____

Parent's Name: _____

What are your child's usual sleep times at home?

_____

How long does your child usually sleep at one time?

_____

What does your child usually sleep in?

___ Cradle ___Crib ___Other - _____

Does your child use a pacifier to go to sleep with?

___ Yes ___No

Do you utilize any other items to help your child sleep? (i.e. sleep sack, etc)

___ No ___Yes - _____

Is your child able to roll over back to tummy?

___ Yes ___No

Is your child able to roll over tummy to back?

___ Yes ___No

Teacher Use Only

Child rolled over for the first time

____ Back to front - _____/_____/_____

____ Front to back- _____/_____/_____

Parent Acknowledgement (please initial & date below)

_____ _____/_____/_____

Do you have a medical exemption from your doctor advising us of any specific sleep needs for your child?

___ Yes (if so, please attach a copy) ___No

I certify that the above information about my child's current sleep habits and capabilities is true and accurate.

Signed:_____ Date: _____/_____/_____