INFANT / TODDLER DEVELOPMENT PLAN

*** Infants: 6 weeks- 17 months**

*** Toddlers: 18 months- 23 months**

CHILD _____ BIRTHDATE _____

PARENT _____ CAREGIVER _____

SLEEPING ROUTINE

Pre-Nap Routines _____

How many naps per typical day? _____

What times? _____

Waking behavior/ routine _____

Special Concerns _____

! BACK TO SLEEP IS REQUIRED!

EATING ROUTINE

LIQUIDS:

How does your child receive liquids?

Bottle _____ sippy cup _____ cup _____ other _____

JUICE:

What kind? _____

When? _____

Amounts: _____

MILK/ FORMULA:

What kind? _____

When? _____

Amounts: _____

OTHER:

What kind? _____

When? _____

Amounts: _____

SOLIDS:

Type? _____

_____

When? _____

_____

Amount: _____

_____

Does your child eat unassisted? _____ Does he/she enjoy eating? _____

How is your child fed? Held in lap? _____ Highchair? _____ Other? _____

Parent suggestions for feeding _____

_____

Any special feeding problems _____

_____

Any known FOOD ALLERGIES _____

_____

What kind of food does he/ she like? _____

_____

What food does he/ she NOT like? _____

_____

ANY FOOD RESTRICTIONS/ ALLERGIES MUST BE ACCOMPANIED BY A DOCTOR'S STATEMENT

DIAPERING ROUTINE

Type of diapers/ pull ups used: _____

Is child's skin highly sensitive? _____ Frequent diaper rash? _____

Please indicate if any of the following are used (indicate brand names)

Oil _____ Powder _____ Lotion _____

Ointment _____ Other _____

ibe any special diapering procedures _____

_____

Are bowel movements regular? _____ How many per day? _____

Approximate times _____

Is diarrhea _____ or constipation _____ a problem?

TOILETING ROUTINE

Has toilet learning been attempted? _____ If so, at what age? _____

How is the child doing? _____

What is the child's name for bowel movement? _____

What is the child's name for urination? _____

Is a potty chair used at home? _____ Or toilet seat? _____

! IF ANY MEDICATED PRODUCT IS USED, IT MUST BE ACCOMPANIED BY A MEDICATION ORDER FORM SIGNED BY THE PARENT AND THE DOCTOR!

HEALTH AND GROWTH INFORMATION

Does the child have a "fussy" time? _____ When? _____

How is this handled? _____

_____

_____

Does the child sit up by him/ herself? _____ Crawl? _____

Pull up? _____ Stand? _____ Walk? _____

Does the child dress/ undress self? _____ Ride a tricycle? _____

Climb steps unassisted? _____ Slide down a slide unassisted? _____

Does child need constant adult attention? _____

Can child amuse him/herself any time during the day? _____ If so, for how long? _____

ACTIVITY ROUTINE

At home, my child can do the following activities _____

_____

_____

I would like my child to learn to do the following activities _____

_____

_____

Are there any special considerations that the staff needs to know about your child? _____

_____

_____

*THIS CENTER ENSURES THAT, **DAILY**, EVERY CHILD IS:*

- *HELD, PLAYED WITH AND TALKED TO;*
- *EXCEPT WHEN SLEEPING, GIVEN OPPORTUNITIES TO SIT, CRAWL, TODDLE, OR WALK OUTSIDE THE INFANT'S CRIB;*
- *EXCEPT IN INCLEMENT WEATHER, TAKEN OUTDOORS*

ENROLLMENT DATE _____

X _____ X _____

Parent/ Guardian Signature Date

X _____ X _____

Primary Caregiver Signature Date

THIS FORM IS REQUIRED TO BE UPDATED EVERY THREE MONTHS, OR SOONER IF REQUESTED BY THE PARENT/ GUARDIAN OR STAFF.