



INFANT INDIVIDUALIZED CARE PLAN

This information will be kept in your child's classroom file as a reference for teachers and staff.

Infant's Full Name: _____ Date of Birth: _____

Nickname (if any): _____ Language(s) spoken at home: _____

Parent/Guardian Full Name(s): _____

Has anyone other than parents had an important part in the care of your infant? yes no
If yes, when (infant's age)? _____ If yes, who or where? _____

Does your infant have siblings or spend time with other children outside the immediate family? yes no
If yes, with whom (names and ages) _____

Are there any family situations that you would like CLC to be aware of? yes no
If yes, please explain: _____

Are there any "family rules" you would like CLC to be aware of? yes no
If yes, please explain: _____

Does your family celebrate holidays and birthdays or any cultural holidays or traditions? yes no
Please explain: _____

What are your expectations of this program and the teachers? _____

DEVELOPMENT / PERSONALITY

Does your infant get colic? yes no If yes, how do you handle it? _____

Does your infant have a fussy time? yes no If yes, when? _____
If yes, how do you handle it? _____

Does your infant use a pacifier? yes no Does your infant suck his/her thumb/finger(s)? yes no

At what age did your infant begin to: Sit alone? _____ Crawl? _____ Pull up? _____
Walk with support? _____ Walk alone? _____ Name simple objects? _____

Is your infant a good climber? yes no

Does your infant show any indications of speech, vision, or hearing problems? yes no _____

Does your infant have any behaviors that concern you? yes no _____

Does your infant have any fears that you would like CLC to know about? yes no _____

What are your infant favorite toys, games, and activities? _____

DIAPERING

Are your infant's bowel movements regular? yes no How many per day? _____

Is diarrhea a problem? yes no Is constipation a problem? yes no

Is your infant's skin highly sensitive? yes no If yes, how do you treat it? _____

Does your infant have frequent diaper rash? yes no If yes, how do you treat it? _____

SLEEPING

Does your infant usually sleep alone in his/her bed? yes no _____

Who usually puts your infant to sleep? _____

What time does your infant usually:

Go to bed? _____ Wake up? _____ Nap? _____ For how long? _____

Please describe your special way of putting your infant to sleep: _____

Does your infant sleep with something special? yes no _____

Does your infant have any problems sleeping? yes no _____

What is your infant's disposition upon waking?

Happy Grouchy Clingy Slow to wake Other _____

FEEDING

What is your infant's current feeding schedule? _____

Are you breastfeeding? yes no If yes, will you supply breastmilk to CLC? _____

Will you breastfeed at CLC? yes no If yes, will you breastfeed on your or your infant's schedule?

Are you bottle-feeding? yes no If yes, what formula? _____

How has your infant been fed? held in lap in a high chair other _____

What are some of your infant's favorite foods? _____

What are some foods your infant dislikes? _____

Does your infant have any feeding issues or difficulties CLC should know about? yes no

If yes, please explain: _____

~~~This portion is to be completed during the Classroom Visit with parent/guardian and Head Teacher.~~~

Have you introduced whole milk? yes no If yes, when? _____

Have you introduced any other foods? yes no If yes, what foods and when (list below)?

<u>Food</u>	<u>Date</u>	<u>Food</u>	<u>Date</u>	<u>Food</u>	<u>Date</u>	<u>Food</u>	<u>Date</u>

Please list any additional information or concerns you would like to share with CLC: _____

Parent/guardian Name

Signature

Date

I have received the Infant Drop-off Procedure, and we have reviewed this Individualized Care Plan together.

Parent/Guardian Initials: _____ Head Teacher Initials: _____ Visit Date: _____

Infant Classroom Drop-off Procedure

1. Before entering the Infant classroom, you must put on **blue shoe covers**. The covers are located on the counter in the office. There are chairs outside the classroom for you to sit on if needed.
2. **DO NOT** step over the gate. This will ensure your safety, your child's safety, and the safety of the children and staff in the Infant classroom.
3. Upon entering the Infant classroom, you must **wash your child's hands** using the sink by the changing table. This is a DCFS licensing requirement.
4. Please make sure your child arrives ready for the day in a **clean diaper**. If you find that your child needs a diaper change upon arrival, **please change your child's diaper**. You may use the supplies CLC provides.
5. Before leaving the Infant classroom, you must **sign in** your child using your full name and time of arrival.

Thank you for your cooperation!