Individual Care Plan

Child Name: _____ Date of Birth: _____

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

What are you currently offering your child? Please check
Breast Milk_____ Formula: _____Milk: _____Water_____
Normally drinks _____ oz. Every _____ hours

Normally eats at _____, _____, _____, _____, _____(am/pm)

How do you prepare the bottle? Please check
____ Room Temperature ____ Warmed ____ Cold Special Instructions: _____
_____
_____

Does your child hold their own bottle? _____ Yes _____No

Any known allergies? _____

How much does your child usually eat?
Breakfast- Time: _____ Amount: _____
Lunch- Time: _____ Amount: _____
Snack- Time: _____ Amount: _____

How does your child usually eat these foods? Please check
_____Spoon fed _____Uses fingers _____Self-spooned

Does your child have difficulty eating? Please check
_____Spits up _____Chokes easily _____

Does your child use a pacifier? ____ Yes ____No When? _____

Normally naps at _____, _____, _____, for _____ min/hrs

What is the best way to help your child fall asleep? _____
_____

What are some of the things your baby likes to do? _____
_____

Any additional information we should know? _____
_____
_____

_____ _____
Parent/Guardian Signature Date