Infant/Toddler/Young Two Needs & Service Plan

Child's Name_____ DOB_____

Date _____ Teacher_____

Does your child have any allergies? _____ Date for Next Review_____

Does your child have any special needs? _____

Bottle

Does your child take a bottle? _____ Warmed___ Cool ___

What brand of formula? _____ Breast Milk _____

Does Child hold his/her bottle? _____

Does your child have a pacifier? _____

Sippy cup? _____

Regular cup? _____

Feeding

Spoon_____

Fork _____

Food (Infants)

Infants – Date for introducing food _____

Cereal _____ Rice, Oatmeal, Barley

Juices _____ OJ, Apple, Grape

Fruits _____ Apple Sauce, Pears, banana

Vegetables _____ peas, squash, green beans, carrots, spinach

Food (Toddlers)

Strained foods_____

Finger foods _____

Table Foods_____

Milk

Whole Milk – date for introducing milk _____.

Soy Milk_____

Toileting needs:

Child is currently in diapers _____

What is the diapering, what is your usual diapering routine?

_____

_____

_____

Diapering at home is done on _____regular schedule _____as needed

How does child indicate need to be changed? _____fussing _____pulling on diaper _____other way

Where is changing done? ____changing table ____floor ____bed ____other

Do you have a special routine for diapering your child?

_____

_____

_____

Do you use wipes? _____

Do you regularly use any ointments or creams for rashes? _____

Is your child allergic or have they had reactions to any type of wipes/diapers? _____

Type/Brand _____

Toileting Needs (Toddlers)

What age do you feel you would like to start potty training? _____

Plan for child with Academy & Family?

_____
_____
_____

Sleeping:

My child's napping scheduling is: am____ pm____ early afternoon _____ afternoon_____

When my child is tired he/she: gets fussy ____ wants to be held _____ rubs eyes_____ finds a place to lie down_____

At home my child falls asleep: _____on own _____pacifier ____special blanket _____other

_____being feed with bottle/breast feed _____being rocked _____back rubbed or patted

_____listening to a story _____listening to music _____when I lay down with him

My child sleeps: _____lightly and wakes up easily _____sleeps unless there is a lot of noise

_____will sleep no matter how noisy

Other information that will help your child sleep?

_____
_____
_____

Medications

Child on any medications?

Medication_____

Times to be given_____

Dosages_____

What concerns/instructions do you have to help us meet the needs of your child?

_____

_____

_____

I understand Oak Tree Academy will place my child in the class that best meets all his/her needs. After careful consideration, the child's developmental levels and kindergarten start date will be deciding factors for class placement.

Print Parent Name: _____

Parent's signature: _____

Print Teacher Name: _____

Teacher's Signature: _____

Print Director's Name: _____

Director's Signature_____