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 and how often?

☐ **Breast Milk**: _____ oz. Every _____ hours ☐ **Formula**: _____ oz. Every _____ hours

☐ **Milk**: _____ oz. Every _____ hours ☐ **Water**: _____ oz. Every _____ hours

Normally eats at _____, _____, _____, _____, _____

Does your child hold its own bottle? _____ Any known allergies? _____

How do you prepare the bottle?

☐ Room Temperature ☐ Warmed ☐ Cold ☐ Special Instructions: _____

If baby food is to be provided, please provide their schedule below.

How much does your child usually eat:

Breakfast- Time: _____ / Every _____ hours Amount: _____

Lunch- Time: _____ / Every _____ hours Amount: _____

Snack- Time: _____ / Every _____ hours Amount: _____

How does your child usually eat these foods?

☐ Spoon fed ☐ Uses fingers ☐ Self-spooned

Does your child have difficulty eating? ☐ Spits up ☐ Chokes easily

Does your child use a pacifier? _____ 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