

**Individual Care Plan**

Child Name: Enter Child’s Name Date of Birth: Select Date

Has your child stayed with anyone else besides parents? Select Option

If so, who?  Enter Response

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 : Enter Time, Enter Time, Enter Time, Enter Time, Enter Time, Enter Time

Does your child hold its own bottle? Select Option Any known allergies? Enter 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: Enter Time / Every # hours Amount: Oz

 Lunch- Time: Enter Time / Every # hours Amount: Oz

 Snack- Time: Enter Time / Every # hours Amount: Oz

How does your child usually eat these foods?

 ☐ Spoon fed ☐ Uses fingers ☐ Self-spooned

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

Does your child use a pacifier? Select Option When? Enter Response

Normally naps at Enter Time, Enter Time, Enter Time, Enter Time, Enter Time

For Enter Length min/hrs

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

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

Any additional information we should know? Enter Response

 Enter Parent Name Select Date

 Parent/Guardian Signature Date