

Baymonte Christian School Infant and Toddler Needs and Services Plan

Child's Name: _____ Date of Birth: _____ Age: _____

Food:

**Food Allergies: _____

Infant Feeding Schedule: _____

Milk Type: Breast Milk: _____ Formula: _____ Other: _____ Uses: Bottle: _____ Sippy Cup: _____

Feeding Schedule (for Infants eating solid foods):

Food Type: Pureed: _____ Cut Pieces/Bites: _____ Spoon Fed: _____ Feeds Self: _____

Comments: _____

Typical Daily Feeding Schedule: _____

Breakfast: _____ A.M. Snack: _____

P.M. Snack: _____

Food Likes: _____ Food Dislikes: _____

Sleep:

Sleeping Habits: _____

Pacifier: _____ Special Blanket: _____ Rock to Sleep: _____ Position of Sleep: _____

Misc. Information/Instructions: _____

What are your child's sleeping habits at night? _____

What time does your child typically wake up in the morning? _____

Does your child have any special sleeping item(s)? _____

Does your child nap? _____ Usual Nap Routhines: _____

General Health:

Allergies: _____

Medication: _____