UC Merced Early Childhood Education Center
Infant Needs and Service Plan

This form will be reviewed with the Director during your enrollment orientation. Please fill out all the information you can prior to your orientation. The Infant Needs and Service Plan will be used in the classroom by the teachers working with your infant to provide individualized care.

Child's Name _____ (prefers to be called)_____

Birthdate _____

Parent(s) Name(s)_____

Briefly describe your pregnancy (easy, was ill often, had external stressors)

_____

_____

Briefly describe your child's birth experience (vaginal, c-section, length of labor, any complications)

_____

Briefly describe your child's first months of life (feeding, sleep/ play patterns, illnesses, temperament)

_____

_____

How does your child generally react to separation from you?

_____

_____

Name one or two of your child's characteristics or mannerisms which you find most endearing.

_____

_____

Does your child have any fears or strong dislikes?

_____

_____

Please describe your techniques for soothing your child when he or she is tired, hurt, upset or just needs some special comforting.

_____

_____

PLAY/EXPLORATION TIME: What type of apparatus does your child spend a majority of his/her time in (sling, front pack, adult arms, floor, boppy, swing, car seat, etc)?

_____

Does your child need you with them consistently or can s/he spend awake time alone?_____

For how long a time?_____

EATING: If breast-feeding, will you come to the ECEC to breast feed? _____

If so, at what time?_____ If not, will you send breast milk?_____

Is your child using a bottle?_____ If so, at what times of day? _____

Special word for bottle_____

The bottle contains: ☐ Breast Milk ☐ Formula(Type of Formula):_____

☐ Whole Milk ☐ Water ☐ Fruit Juice ☐ Other:_____

Frequency of nursing/bottles/meals:_____

Kind of food preferred:☐ Baby food ☐ Finger food ☐ A combination

Does s/he use any eating utensils? _____Does s/he drink from a cup? _____

Does your child have any food allergies we need to be aware of?

_____

NAPPING: How will we know your child is tired and ready to sleep?_____

_____ Number per day_____ time(s) or frequency:_____

General length child sleeps at each nap:_____

Routine to get to sleep (i.e. swaddle, song, rocking, swing, put into crib, pacifier, nurse/bottle):_____

We put babies to sleep on their backs. Is your baby use to sleeping on his/her back?_____

Any concerns about sleeping at the ECEC (light levels or noise)?_____

_____

DAILY ROUTINE: Summarize your child's daily schedule. List feedings, awake and sleep sequences.

Morning:_____

Afternoon:_____

Evening:_____

Overnight:_____

TOILETING: Special words for urination:_____ Bowel movement:_____

Is your child doing any toileting?_____ (if toileting, a Toilet Training Plan will be completed)

Is your child using diapers?_____ Cloth : ☐ Disposable: ☐

You know your child needs a new diaper when (brings a new diaper to you, cries, you have to check, goes off to the side for privacy)

_____

OTHER: Does your child use a pacifier? _____ When?_____

Special word for pacifier_____

Does your child have a special way (rocking, singing, pacifier, or lovey) that helps to sooth when upset?_____

_____

Does your child have any allergies, speech or hearing challenges or any other special needs or conditions of which we should be aware?

_____

_____

What else should we know in order to provide sensitive individualized care for your child?

_____

_____

_____

_____ _____

Parent's Signature Date

_____ _____

Director's Signature Date