

## INFANT/TODDLER NEEDS & SERVICE PLAN

|                     |                      |  |
|---------------------|----------------------|--|
| Child's Name: _____ | Date of Birth: _____ | Service Options: ___ Center Based<br>___ Home Based ___ FCCH<br>Location _____ |
|---------------------|----------------------|--|

**Please circle or write your answers to the following questions. Today's Date:** \_\_\_\_\_

|  |  |
|--|--|
| <p>1. Is your child on a special diet? Yes/No<br/>If yes, what diet? _____<br/>_____</p> <p>2. Is your child allergic to any foods? Yes/No<br/>If yes, what? _____<br/>_____</p> <p>3. Are there any foods your child should not eat for medical, religious, or personal reasons? Yes/No If yes, what? _____<br/>_____</p> <p>4. Has there been a big change in your child's appetite in the last month? Yes/No If yes, what? _____<br/>_____</p> <p>5. Does your child ever eat things like plaster, dirt, clay, or paint chips? Yes/No _____<br/>_____</p> | <p>6. Does your child take a bottle? Yes/No<br/>During the day _____ At night _____<br/>What do you put in the bottle? _____<br/>What type of bottles and nipples are used at home?<br/>_____</p> <p>7. How many meals does your child eat each day? _____</p> <p>8. How many times a day does your child eat a snack? _____</p> <p>9. Special likes and dislikes:<br/>_____<br/>_____<br/>_____<br/>_____</p> |
|--|--|

### Feeding Information

|                           | Meal    | Type | How Much | How Often |
|---------------------------|---------|------|----------|-----------|
| Breastmilk                | B L D S |      |          |           |
| Formula                   | B L D S |      |          |           |
| Infant Cereal             | B L D S |      |          |           |
| Strained Vegetables       | B L D S |      |          |           |
| Strained Fruits           | B L D S |      |          |           |
| Strained Meats & Proteins | B L D S |      |          |           |
| Dairy Products            | B L D S |      |          |           |
| Drink                     | B L D S |      |          |           |
| Table Foods               | B L D S |      |          |           |
| Other                     | B L D S |      |          |           |

My child uses a:    Bottle    Cup    Fork    Spoon

### Sleeping Information

What are your child's sleeping patterns? \_\_\_\_\_  
\_\_\_\_\_

### Toileting Information

How many wet diapers a day? \_\_\_\_\_ How often does your child have bowel movements? \_\_\_\_\_

When? \_\_\_\_\_ Any changes in urine or stool? \_\_\_\_\_

Explain: \_\_\_\_\_

Has use of toilet been introduced at home? Yes \_\_\_\_\_ No \_\_\_\_\_ If so, how? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does your child have any fears or concerns regarding toileting? \_\_\_\_\_

Do you wish your child to use disposable diapers or training pants? \_\_\_\_\_