



## INDIVIDUAL INFANT CARE PLAN

We believe that Premier Learning is an extension of your home. In an effort to carry this philosophy into our daily schedule with your child, we would appreciate the following information from you. We encourage you to talk personally with your child's teacher with regards to this plan. Please update this form each month until your child is 12 months of age.

Child's Name \_\_\_\_\_ D.O.B \_\_\_\_\_ Today's Date \_\_\_\_\_

### I. DAILY FEEDING AND EATING

A. Method of Feeding (Check all that apply)

spoon     warm bottle     high chair  
 cup     holds own bottle     feeding chair  
 bottle     feeds self     other \_\_\_\_\_

B. Type	Time(s)	Amount
<input type="checkbox"/> Breastmilk	_____	_____
<input type="checkbox"/> Formula	_____	_____
<input type="checkbox"/> 2% milk	_____	_____
<input type="checkbox"/> Wholemilk	_____	_____

Type	Times(s)	Amount
<input type="checkbox"/> infant food	_____	_____
<input type="checkbox"/> junior food	_____	_____
<input type="checkbox"/> table food	_____	_____

C. Special Instruction / Preparation \_\_\_\_\_  
\_\_\_\_\_

D. Allergies \_\_\_\_\_  
\_\_\_\_\_

### II. SLEEPING INSTRUCTIONS

AM nap (time) \_\_\_\_\_ / \_\_\_\_\_     Sleeps with blanket     Pillow (on cots only)  
 PM nap (time) \_\_\_\_\_ / \_\_\_\_\_     Sleeps on back     Sleeps on side  
 Sleeps on tummy (infants over 6 months)  
 Other info \_\_\_\_\_

Pacifier Type \_\_\_\_\_ (must be labeled with child's name)

Pacifier Use  any time     only naptime     not at all     other \_\_\_\_\_

III. **TEMPERAMENTS** – Please describe how your child responds to challenges in activities or environment (adapts easily, warms up slowly, resistant to change, etc.) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

IV. **DEVELOPMENTAL GOALS** – Please list or describe the skills your child is working on at home or goals you have for your child this month. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_