Infant Development Plan

Name of Child_____Birthdate_____

Sleeping Routine

Pre-nap Routine: _____

How many naps per day? _____ Length of naps: _____

What times does he/she take naps? _____

How do you place your child when sleeping? _____
(We ALWAYS place infants on their backs unless parent provides a Doctor's note specifying otherwise)

Waking Behavior/ Routine: _____

Special Concerns: _____

Eating Routine

Liquids

Juice:

What kind?_____When? _____

Amount? _____

Does he drink from a bottle or a cup? _____

Milk/ Formula:

What kind?_____When? _____

Amount? _____

Does he drink from a bottle or a cup? _____

Other:

What kind?_____When? _____

Amount? _____

Does he drink from a bottle or a cup? _____

Solids:

Type? _____

When? _____

Amount? _____

Does your child eat unassisted? _____ Does your child enjoy eating? _____

How is your child fed? ____ Held in Lap? ____ High Chair? ____ Other? ____

Parents' suggestions for feeding: _____

Any special feeding concerns? _____

Any known Food Allergies? _____

What is your child's favorite food? _____

Is there any food that your child dislikes? _____

Diapering Routine

Type of Diapers used: _____ Type of Wipes used: _____

Is your child's skin highly sensitive? _____Frequent Diaper Rash?_____

Indicate if any of the following are used (List Brand Names)

Oil _____ Powder _____ Lotion _____

Ointment _____ Other _____

If any medicated product is used, it must be accompanied with a medication order form signed by a Doctor.

Describe any special diapering procedures: _____

_____

Are bowel movements regular? _____ How many per day? _____

Approximate times? _____

Special Concerns? _____

Health and Growth Information

Does your child have a "fussy" time? _____ When? _____

How is this handled? _____

Does your child:

Dress/Undress self? _____ Ride a tricycle? _____

Climb steps unassisted? _____ Slide down a slide unassisted? _____

Does your child have any allergies, besides food? _____

Does your child take medication on a regular basis? _____

Any medication dispensed while at Stepping Stone, must be accompanied with a medication order form signed by a Doctor.

Activity Routine

At home, my child can do the following activities: _____

_____

I would like my child to work on the following activities while at Stepping Stone: _____

_____

Are there any special considerations the staff needs to know about your child?

_____

_____

Stepping Stone Children's Center ensures that, daily, every child is:

- **Held, played with and talked to.**
- **Given opportunities to sit, crawl, toddle or walk outside of the crib.**
- **Taken outside, weather permitting.**

This form will be updated every two months, or sooner if requested by the staff or parent/guardian.

_____ _____

Parent/Guardian Signature Date