THE SUMMIT
EARLY LEARNING ACADEMY

Individual Care Plan

Child Name: _____ Date of Birth: _____

Has your child stayed with anyone else besides parents? _____

If so, who? _____

What are you currently offering your child and how often?

Breast Milk: _____ oz. Every _____ hrs **Milk**: _____ oz. Every _____ hrs

Formula: _____ oz. Every _____ hrs **Water**: _____ oz. Every _____ hrs

Normally eats at: _____ , _____ , _____ , _____ , _____ , _____

Does your child hold its own bottle? _____ Any known allergies? _____

How do you prepare the bottle?

___ Room Temperature ___ Warmed ___ Cold Special Instructions: _____

If baby food is to be provided, please provide their schedule below.

How much does your child usually eat:

Breakfast- Time: _____ / Every _____ hrs Amount: _____

Lunch- Time: _____ / Every _____ hrs Amount: _____

Snack- Time: _____ / Every _____ hrs Amount: _____

How does your child usually eat these foods?

___ Spoon fed ___ Uses fingers ___ Self-spooned

Does your child have difficulty eating? ___ Spits up ___ Chokes easily Other: _____

Does your child use a pacifier? _____ When? _____

Normally naps at: _____ , _____ , _____ , _____ For _____ min/hrs

What is the best way to help your child fall asleep? _____

What are some of the things your baby likes to do? _____

Any additional information we should know? _____

_____ _____

Parent/Guardian Signature Date