Embracing Equality and Diversity

Infant/Toddler Individual Activity Plan and Feeding Schedule

(UPDATE WITH CHANGES OR EVERY THREE MONTHS)

Child's Full Name: _____ Date of Birth: _____

Primary Child Care Staff Assigned: _____ Shift/Time: _____

Circle Type(s) of liquids you are currently offering your child: Breast Milk Formula Juice Water Other: _____

How much/ how often: _____

Do you offer cereal with your formula: ____ yes ____ no How much/often: _____

Do you mix cereal with fruit/vegetables? ____ yes ____ no How much/often: _____

List below any foods other than milk/formula that are offered to your infant/toddler:

Type of Food: Amount of Food: How often:

_____

_____

_____

Circle how your child usually eats these foods: Spoon-fed Uses fingers Self-spooned Other: _____

Does your child have difficulty eating? ____ yes ____ no (Spits up, chokes easily) Other: _____

Does your child have any food/liquid allergies? (If yes, please list the allergies): _____

_____

What does your child like to fall asleep/nap? (Rocked, patted, back rubbed, swaddled) _____

_____ [We must place infants in cribs for nap/sleep on their backs unless we have a doctor's note on file to use restrictive devices; wedge, roll, strap, etc.]

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

Please list a daily schedule of what your child does during the days: _____

_____

_____

_____

Please list any other information we need to know about you infant/toddler: _____

_____

_____

Parent/Guardian signature: _____ Today's Date: _____

Initials and Date: _____ _____ _____ _____ _____

Location 1:
Hope Grows Child Development Center
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Location 2:
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