COMMUNITY ACTION OF SOUTHEAST IOWA
Early Head Start Program

INFANT/TODDLER NEEDS AND SERVICES PLAN

Date:____
Child's Name:______________________________________ Birth Date/Age of Child________________
Parent(s) Name:____

Fill out Section 1 for children 0-1 years old. Fill out Section 2 for children 1-3 years old.

Section 1

Sleeping Routine (Infants will be put to sleep on back in EHS)

Pre-nap routines/rituals: ____
____
How many naps per day (typically): (times of day & length of naps) ______________________________
____
What sleeping position does your child prefer? ____
Special concerns: ____

Comforting/Distress

Does your child have a security object? Name?____
Does your child use a pacifier? When?____

Diapering Routine

Disposable diapers are provided at Early Head Start. If your child has an allergy or health issue to a particular brand, please indicate the brand/type of diaper you use.________________________________

If the child needs diaper ointment/cream, you must supply a tube for their own use.
We will supply sunscreen lotion.
On your child's physical there is a place that will need to be marked by your physician allowing staff to administer diaper rash ointment or sunscreen lotion.

Bottle/Cup Routine

Circle: Bottle Cup

Formula: Brand__________________________________ Amount__________________________________
Time of day you want given________________
Breast Milk: __________________________________ Amount__________________________________
Time of day you want given________________
Juice: Type___________________________________ Amount__________________________________
Time of day you want given________________

We follow the WIC guidelines and begin whole milk with your infant at one year of age.

Introducing Solids

We follow the WIC guidelines and/or recommendations from your physician for vegetables, fruits, and their juices, protein such as cheese, yogurt, cooked beans, meat, fish, chicken, and egg yolk, whole egg, and milk. We also can introduce the use of a cup and a spoon at 8-10 months, unless it is not appropriate for your child. Exceptions will be made if a nutrition related health concern is diagnosed by a health professional. Documentation will be required to make individual accommodations.

Eating Routine

Baby Cereal: ___________________________Time of day & amount you want given: ___________________
Baby Food: ____________________________Time of day & amount you want given: ___________________
Table Food: ____________________________Time of day & amount you want given: ___________________
Food Allergies:____
Food dislikes or eating problems:____
Food likes and eating preferences:____
Special diet/requests:____
____
Special concerns:____

Does your child have any services that are different then those provided by the center's routine program? i.e., special exercises, special materials, accommodation of special services.

____
____
____

Other information: ____
____
____

The Infant/Toddler Needs and Services Plan will be updated every year or as needed.

Parent Signature: ____ Date: _______________________

Staff Signature: ____ Date: ________________________

Date of Change__________________ Parent Initial_________________ Staff Initial__________________

Date of Change__________________ Parent Initial_________________ Staff Initial__________________

Date of Change__________________ Parent Initial_________________ Staff Initial__________________

Date of Change__________________ Parent Initial_________________ Staff Initial__________________

Date of Change__________________ Parent Initial_________________ Staff Initial__________________

Section 2

Sleeping Routine

Pre-nap routines/rituals: ____
____
How many naps per day (typically): (times of day & length of naps) ___________________________
____
Special concerns: ____

Comforting/Distress

Does your child have a security object? Name?____________________________________
Does your child use a pacifier? When?____________________________________

Diapering Routine

Disposable diapers are provided at Early Head Start. If your child has an allergy or health issue to a particular brand, please indicate the brand/type of diaper you use.___________________________

Is your child wearing (circle): Diapers Underwear Both

If wearing underwear, how often do you take them to the bathroom? _________________________

Underwear is available when accidents occur, although spares from home can be kept with their spare set of clothes in their cubbies.

If the child needs diaper ointment/cream, you must supply a tube for their own use.
We will supply sunscreen lotion.
<u>On your child's physical there is a place that will need to be marked by your physician allowing staff to administer diaper rash ointment or sunscreen lotion.</u>

Eating Routine (1-2 year olds whole milk and 2-3 year olds 1% milk)

Your child will be served the food as provided and regulated by the Child and Adult Care Food Program. Exceptions will be made if a nutrition related health concern is diagnosed by a health professional. Documentation will be required to make individual accommodations.

Does your child use: Cup Sippy Cup
Table Food (Check all that apply to your child's day):
Breakfast __________ A.M. Snack __________ Lunch __________
P.M. Snack __________ Supper__________ Bedtime __________
Food Allergies:____
Food dislikes or eating problems:____
Food likes and eating preferences:____
Special diet/requests:____
____
Special concerns:____

Does your child have any services that are different then those provided by the center's routine program? i.e., special exercises, special materials, accommodation of special services.

____
____
____

Other information: ____
____
____

The Infant/Toddler Needs and Services Plan will be updated every year or as needed.

Parent Signature: ____ Date: ____________________

Staff Signature: ____ Date: ____________________

Date of Change________________ Parent Initial________________ Staff Initial________________

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