Individual Personal-Care Plan for Infants and Toddlers

Child’s Name _______________________________

Date of Birth ________________________________

What would you like us to call your child? ____________________________________________

Developmental History

Type of birth: __________________ Complications: __________________

Age child began: sitting ______ crawling _____ walking _____ talking ______

Does child: sit up ☐ pull up ☐ crawl ☐ walk with support ☐

Times child may be fussy: ________________________________________________

How do you handle these fussy times? ____________________________________________

Family Information

With whom does child reside? ________________________________________________

Who else lives in the home (siblings, extended family, pets)? ______________________

What does the child call family members? _______________________________________

Language(s) spoken at home: _________________________________________________

Are books read in languages other than English? _______________________________

Are there words/phrases in home language that we should know? _________________

Are there cultural or family customs, rituals, or traditions that will help us make your child’s experience more meaningful? ______________________________________

Are there other matters or concerns you feel are important? ______________________

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Health/Development

Describe any serious illnesses or hospitalizations: ______________________________

_____________________________________________________________________

Any history of colic? ____________________________________________________

_____________________________________________________________________

Describe any special physical conditions, disabilities, or allergies: _________________

_____________________________________________________________________

Has your child been diagnosed with a special need? ____________________________

If so, is your child receiving any special services? _____________________________

_____________________________________________________________________

Regular medications? _______________________________________________________________________

_____________________________________________________________________

Bottle/Cup Routine

Circle: Bottle  Cup

Breast Milk: ________ Amount ________ Time of day you want given ________

Formula: ______________ Brand ______________ Amount ________

Time of day you want given _______________________________________________

Milk: __________________ Type __________________ Amount ________

Time of day you want given _______________________________________________

Juice: __________________ Type __________________ Amount ________

Time of day you want given _______________________________________________

Introducing Solid Foods

We recommend introducing infant cereal at 4–6 months; vegetables, fruits, and juices at
5–7 months; protein such as cheese, yogurt, cooked beans, meat, fish, chicken, and egg
yolks at 6–8 months; whole eggs at 10–12 months; and milk at 12 months. We can
introduce the use of a cup and spoon at 8–10 months.

If you do not wish to follow our recommendations, please sign and comment on
your preferences: _______________________________________________________

_____________________________________________________________________

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Eating Routine

Any food allergies? _____________________________________________________

Solid Food: _______________ Time of day you want given: _______________

Food likes and eating preferences: _______________________________________

Food dislikes or eating problems: _______________________________________

Special diet/requests: _________________________________________________

Special characteristics or difficulties? _________________________________

Child eats: □ on lap □ in high chair □ other ________________________

Child eats with: □ spoon □ fork □ hands □ other ____________________

Toilet/Diapering Habits

Does your child have frequent diaper rash? _______________________________

Do you use: □ oil □ powder □ lotion __________ □ other __________

Does child wear: □ disposable diapers □ cloth diapers

Are bowel movements: □ regular How often: ___________________________

Is there a problem with: □ diarrhea □ constipation

Is your child toilet trained: □ urination □ bowels

What is used at home: □ potty chair □ special seat □ regular seat

Word used for urination: _______________ bowel movement: _______________

Does the child have accidents? ________________________________________

Comforting/Distress

Does your child have a security object? __________ Name? _______________

Does your child use a pacifier? _______________ When? _______________

Other information? __________________________________________________

What comforting objects would you like your child to have at the program?
Sleeping Routine

Does child sleep in: □ crib    □ bed    □ family bed

Pre-nap routines/rituals: __________________________________________________

How many naps per day (typical): AM _______ to ______ PM _____ to _____

Length of nap: _________________________________________________________

In what position does your child prefer to nap: ______________________________

Waking behavior/routine: _________________________________________________

Special concerns: _________________________________________________________

What time does child go to bed at night:__________ awake in morning: ________

Are there any sleeptime rituals? __________________________________________

Separation

Has your child been left in the care of someone other than yourself? □ yes □ no
If so, with whom? _______________________________________________________

What difficulty does your child experience separating from you? _______________

What are some ways to calm your child? _____________________________________

What are your feelings about leaving your child in our care? __________________

How can we help you feel more comfortable and involved in the care of your child? __

Social Relationships

Has your child had any experience playing with other children? _________________

Would you characterize your child as often:
□ friendly    □ aggressive    □ shy    □ withdrawn

Reaction to strangers? _____________________________________________________

Have you had any previous child care experience? ____________________________

If so, did it meet your needs and expectations? _______________________________

Explain: __________________________________________________________________

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Does your child prefer to play: □ alone □ in small groups
Favorite toys and activities? ________________________________________________

Is your child frightened by:
□ animals □ rough children □ loud noises □ darkened rooms
Explain: ________________________________________________________________

What is your style of guidance and discipline? ________________________________
_____________________________________________________________________
_____________________________________________________________________

**Daily Schedule**

Please describe by approximate time your child’s current daily activities (that is, awakening, eating, time out of crib, napping, toilet habits, fussy time, evening bedtime):

**Morning**
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

**Afternoon**
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

**Evening**
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

**Parenting Philosophy**

Do you have ideas about parenting that would help us to better care for your child?
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

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What do you as a family hope to get out of this child care experience?

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

We will update the personal care plan every 3 months, or sooner if requested by a parent/guardian or as needed by the staff.

Parent Signature ______________________________________ Date ______________

Staff Signature _______________________________________ Date ______________

Date of change ________________ Parent Initials _________  Staff Initials _______

Date of change ________________ Parent Initials _________  Staff Initials _______

Date of change ________________ Parent Initials _________  Staff Initials _______