

### Infant Needs and Services Plan

Child's Name: \_\_\_\_\_ Child's Birth Date/Age: \_\_\_\_\_

Parent(s) Name(s): \_\_\_\_\_

Primary Caregiver: \_\_\_\_\_

#### Infant Sleep Plan

Each infant 12 months and under, will have the attached LIC 9227 Infant Sleeping Plan completed prior to enrollment and updated, as needed, to reflect when the child begins to roll from front to back and back to front. Each infant over the age of 12 months will have the Sleeping Routine section completed below.

#### Sleeping Routine

What is your child's sleeping arrangement at home? \_\_\_\_\_

\_\_\_\_\_

Pre-nap Routines: \_\_\_\_\_

\_\_\_\_\_

How many naps per day (typical): a.m. \_\_\_\_\_ to \_\_\_\_\_ p.m. \_\_\_\_\_ to \_\_\_\_\_

Length of nap: \_\_\_\_\_

What position does your child prefer? \_\_\_\_\_

Waking behavior/routine: \_\_\_\_\_

Special considerations: \_\_\_\_\_

#### Comforting/Self-soothing

Does your child have a security object? **Yes/No**

If yes, what? \_\_\_\_\_ What does your family call it? \_\_\_\_\_

Does your child use a pacifier? **Yes/No** What does your family call it? \_\_\_\_\_

Other information? \_\_\_\_\_

#### Bottle Routine

Shasta Head Start recommends weaning infants from bottle feeding by 1 year of age. Breastfed: **Yes/No**

If yes, will you be providing breast milk for use at the center or feeding your baby on-site?

\_\_\_\_\_

Formula: Brand: \_\_\_\_\_ Type: \_\_\_\_\_

Bottle/Nipple Type: \_\_\_\_\_

How much does your baby drink per feeding? \_\_\_\_\_

How often does your baby nurse or have a bottle? \_\_\_\_\_

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### Cup Routine

We will offer water, formula or milk in an open cup to give your baby an opportunity to learn how to drink from an open cup.

Introduction of cup: What age? \_\_\_\_\_ Type used at home: cup with lid or open cup

Milk: Type: \_\_\_\_\_

### Mealtime Routine

We recommend beginning solid food introduction with rice cereal at 6 months to give your baby additional iron. Other foods will be offered one at a time to watch for potential reactions. Please refer to the Checklist for Solid Food Introduction for more information.

Allergies: \_\_\_\_\_

Food Likes: \_\_\_\_\_ Food dislikes: \_\_\_\_\_

Special diet/requests: \_\_\_\_\_

### Diapering Routine

What size diaper does your child use? \_\_\_\_\_

Which diaper would you prefer your child use? \_\_\_ diapers provided by center **or** \_\_\_ supply your own diapers

If your child needs diaper ointment, you must sign the Diaper Ointment permission form.

Please specify ointment brand: \_\_\_\_\_

### Other Information or Services

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

\_\_\_\_\_

Other information you would like us to know about your child or family routines:

\_\_\_\_\_

The Needs and Services Plan will be updated every three months or sooner if requested by parent or guardian.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Updates

Date: \_\_\_\_\_ Change: Yes \_\_\_ No \_\_\_ Parent Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Change: Yes \_\_\_ No \_\_\_ Parent Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Change: Yes \_\_\_ No \_\_\_ Parent Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Change: Yes \_\_\_ No \_\_\_ Parent Signature: \_\_\_\_\_

Shasta Head Start Child Development, Inc.  
**Infant Needs and Services Plan**

State of California – Health and Human Services Agency

California Department of Social Services

**INDIVIDUAL INFANT SLEEPING PLAN**

Date of plan: \_\_\_\_\_

**SECTION A: INFANT'S INFORMATION**

Infant's Name	Gender	Birth Date
_____	_____	_____
Authorized Representative's Name (Primary Contact)	Phone Number	
_____	_____	
Authorized Representative's Name (Secondary Contact)	Phone Number	
_____	_____	

**SECTION B: SLEEPING ENVIRONMENT INFORMATION**

At home, the infant sleeps in: <input type="checkbox"/> Crib <input type="checkbox"/> Play Yard <input type="checkbox"/> Other (Specify) _____	What are the Infant's usual sleeping hours? _____ _____
What is the infant's average length of the Infant's nap(s) during the day time? _____ minutes   _____ hours	Does the infant use a pacifier? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes If <b>yes</b> , brand: _____

**SECTION C: INFANT'S ABILITY TO ROLL**

My child, \_\_\_\_\_ is able to roll from their back to their stomach and stomach to their back beginning \_\_\_\_ / \_\_\_\_ / \_\_\_\_.

Authorized Representative Signature	Date
_____	_____

**SECTION D: INFANT'S ABILITY TO ROLL IN CHILD CARE**

Provider observed the infant is capable of rolling from their back to their stomach and stomach to their back.

Provider Signature	Date
_____	_____
Authorized Representative Signature (To be completed no later than the next business day following observation)	Date
_____	_____

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**SECTION E: MEDICAL EXEMPTION**

Does the infant have a medical exemption?  Yes  No

If the infant has a medical exemption to sleep in a position other than on their back a licensed physician must provide instruction on an alternate sleeping position.

The following shall be included with the medical exemption:

- Instructions on how the infant shall be placed to sleep, including sleep position.
- Duration the exemption is to be in place
- The licensed physician's contact information
- Signature of the licensed physician and date of signature

ATTACH REQUIRED DOCUMENTS TO THIS FORM AND MAINTAIN IN THE INFANT'S FILE PURSUANT TO TITLE 22, SECTION 101429(a)(2)(c) FOR CHILD CARE CENTERS OR SECTION 102425(c)(2) FOR FAMILY CHILD CARE HOMES.

**I certify that all information contained in this form is complete and accurate to the best of my ability.**

Authorized Representative Signature

Date