INFANT PERSONAL CARE PLAN
DEVELOPMENTAL HISTORY FORM

Today's Date: _____ Date of Enrollment/Transition: _____

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

Date of Last Physical (for WA State only): _____

What would you like us to call your child?:_____

Parent/Guardian Name: _____

Parent/Guardian Name: _____

Name of Person Completing Form: _____

Primary Caregiver: _____

Classroom: _____

FAMILY INFORMATION

In the columns below list the names of family members residing with the child. Please include siblings, extended relatives, and pets. For each person listed provide the name the child uses to address that individual and include ages of siblings.

Name	How child addresses this individual?	Age

Please list the words used in your language corresponding to the words in English. Include additional words in the blank columns if needed.

I'll take good care of you	
I see that you are crying	
Let's change your diaper	
I like your smile	
It's time for your bottle	
Time to eat	
Time for your nap	
Mommy will be back	
Daddy will be back	

If parental custody is shared, describe the custody arrangements: _____

Please tell us about cultural family customs, rituals, or traditions that will help us make your child's experience more meaningful, including languages spoken at home: _____

Infant Personal Care Plan - Developmental History Form

CHILD'S NAME: _____

DEVELOPMENTAL HISTORY

Age Child Began: Sitting: _____ Crawling: _____ Standing: _____ Walking with support: _____

Walking independently: _____ Cooing: _____ Babbling: _____

Saying audible words: _____ Saying 2 or 3 simple sentences: _____

Do you have developmental concerns about your child? _____

How does your child communicate his/her needs? _____

CHILD'S HEALTH

List medications regularly taken and conditions requiring them: _____

Describe serious illnesses or hospitalizations: _____

Describe special physical conditions, disabilities, allergies, or concerns: _____

Does your child have a special need? _____

Explain special services and accommodations, which are different from those provided by the center's routine program (i.e. exercises, equipment, materials, or special services personnel): _____

Note: For documented medical allergies an Allergy Health Care Plan completed by the child's medical provider is required.

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CHILD'S NAME: _____

NUTRITION PRACTICES AND ROUTINES

How is your child fed? Check all that apply: Breast: ☐ Bottle: ☐ Cup: ☐

In the corresponding row, provide your child's feeding details.

	Brand	Amount	Preferred time of day given
Formula/Milk			
Breast Milk			
Juice			

If your baby is exclusively breast fed, please outline your daily plan: _____

If your baby is breast fed or receiving expressed breast milk, how can we support you?_____

List special dietary requests, and restrictions: _____

Have solid foods been introduced? Yes ☐ No ☐ If yes, please identify: _____

Food likes and eating preferences: _____

Child Eats With: Spoon: ☐ Fork: ☐ Fingers: ☐

Child is Fed in: Highchair: ☐ In Arms: ☐ Bouncy Seat: ☐ Other: _____

Preferred time of day to feed child: ☐ A.M. ☐ A.M. ☐ P.M. ☐ P.M.

Additional Information: _____

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CHILD'S NAME: _____

SLEEPING ROUTINES

Pre-nap routines/rituals: _____

_____

_____

_____

Number of naps daily: ___ **From:** _____ **To:** _____ **From:** _____ **To:** _____ **From:** _____ **To:** _____

Preferred sleep position*: _____

At home child sleeps in (Check all that apply: Bassinet: ☐ Crib: ☐ Bed: ☐

Child's typical waking behavior/routine: _____

_____

_____

Special sleeping concerns: _____

_____

_____

Note: Bright Horizons places infants to sleep on their backs in crib unless a waiver has been signed by the parents and the child's physician, stating that the child should be placed in a position other than on his/her back and if allowed by the state licensing agency. Following the recommendation of the American Academy of Pediatrics, soft items such as bumpers, stuffed animals (including pacifiers with a stuffed animal attached), blankets and quilts are not allowed in cribs. The use of sleep or swaddle sacks are recommended for naptime; however, there may be restrictions on the use of and type of these by the state licensing agency.

COMFORTING CHILD

Position child prefers to be held: _____

Security object (if any):_____ Name child uses for object/when needed: _____

_____

_____

Does your child use a pacifier? Yes ☐ No ☐ If yes, when: _____

Describe how adults can comfort your child? _____

_____

_____

DIAPERING/TOILETING ROUTINES

Please check which type of diapers you will provide: disposable: ☐ cloth: ☐

Words used for urination: _____

Words used for bowel movement: _____

_____

_____

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CHILD'S NAME: _____

SOCIAL RELATIONSHIPS

Has your child had any experience with group care? If yes, please describe: _____

How does your child react to new situations and new children and adults? _____

Has your child had previous child care experience? If yes, explain how it met, or did not meet, your expectations? _____

Child's favorite toys and activities: _____

Does your child have any fears? Explain: _____

ADDITIONAL PERTINENT INFORMATION

To help us care for your child as an individual, please explain your parenting philosophy: _____

Is there additional information you feel is important for the staff to know about your child or family? _____

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

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CHILD'S NAME: _____

Sections of this Personal Care Plan will be updated every 3 months or sooner if requested by a parent/guardian.

Parent/Guardian Signature: _____ Date: _____

Staff Signature: _____ Date: _____

Date of Change:		Parent Initials:		Staff Initials:	
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