GLENDALE COMMUNITY COLLEGE
CHILD DEVELOPMENT LABORATORY SCHOOL

Pacific Clinics HEADSTART Early HEADSTART

Pacific Clinics Head Start/ Early Head Start
Early Head Start – Child Care Partnerships

Infant / Toddler Needs and Services Plan

Child's Name:_____ **Enrollment Date:**_____

Parent/Guardian's Name:_____**Date of Birth:**_____

(This plan must be completed and updated every (3) three months for all ages children ages birth to three)

1. Feeding Routines / Schedules / Food Preferences:

Date:_____ ☐ Bottle / ☐ Pacifier ☐ Breastmilk / ☐ Formula Allergies:	Date:_____ ☐ Bottle / ☐ Pacifier ☐ Breastmilk / ☐ Formula Allergies:

Any instructions or added information from **child's physician** regarding diet?

Date:_____	Date:_____

2. Diapering / Toileting:

Date:	Date:
Toileting Plan? Yes ☐ No ☐	Toileting Plan? Yes ☐ No ☐

Has your child started using words or signs for bowel movements and urinating? If so, what are they?

3. Sleeping Routine:

Date:	Date:
Awake:_____ Bedtime:_____ Nap(s):_____ _____	Awake:_____ Bedtime:_____ Nap(s):_____ _____

In what position does your child sleep? *(Infants must sleep on backs at the center due to the risks of SIDS)*

Comments (Please include any concerns):

Parent – Digital Signature	Teacher / Home Educator – Digital Signature
I, _____ have reviewed the form and approve this Needs & Services Plan Form. Date:_____ Reviewed: Yes ☐ No ☐	I, _____ have reviewed the form and approve this Needs & Services Plan Form. Date:_____ Reviewed: Yes ☐ No ☐