RIVERSIDE COUNTY OFFICE OF EDUCATION

Division of Children and Family Services
Early Childhood Education Program

Early Head Start
Needs and Services Plan

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

Enrollment Date: _____ Room:_____ Parent's Name:_____

Does your child have any allergies or special needs?___yes ___no
If yes, please specify: _____

_____

Please also include any special instructions from your physician_____

_____

Do you have any concerns and/or comments about your child?_____

_____

Feeding Information and Individual Plan

What foods have been introduced?	What kind	how much	how often
___breast milk	_____	_____	_____
___formula	_____	_____	_____
___infant cereal	_____	_____	_____
___strained vegetables	_____	_____	_____
___strained fruits	_____	_____	_____
___strained meats and protein	_____	_____	_____
___dairy products	_____	_____	_____
___table foods	_____	_____	_____
___other	_____	_____	_____

What type of bottle nipples are being used at home? _____

If breast-feeding, do you plan to come in and breast feed? ___yes ___no

If yes, when_____

If no, are you going to bring in breast milk, or should the Head Start staff use formula?

_____

What type of formula or milk is your infant/toddler drinking?

Breast _____	Breast_____	Breast_____
Formula_____	Formula_____	Formula_____
Milk_____	Milk_____	Milk_____

What temperature of formula does your child prefer?_____

Cold___	Cold____	Cold___
Warm___	Warm___	Warm___
Room Temperature____	Room Temperature___	Room Temperature__

Has your infant been introduced to solids (baby food)?

___yes	___yes	___yes
___no	___no	___no
please list type:_____	please list type:_____	please list type:_____

Has your toddler been introduced to table foods?

___yes	___yes	___yes
___no	___no	___no
___with fingers/hand	___with fingers/hand	___with fingers/hand
___with spoon	___with spoon	___with spoon

Does your infant/toddler drink from a cup:

___bottle	___bottle	___bottle
___cup with lid	___cup with lid	___cup with lid
___cup	___cup	___cup

Describe your child's eating schedule?_____

What words or gestures does your child use when hungry?_____

What type of baby foods/table foods does your child like? _____

Sleeping:

What is your infant's/toddler's daily sleeping schedule?

Wake_____	Wake_____	Wake_____
Nap(am)_____	Nap(am)_____	Nap(am)_____
Nap(pm)_____	Nap(pm)_____	Nap(pm)_____
Bedtime_____	Bedtime_____	Bedtime_____

What type of bed does your infant/toddler have?_____

Do you rock your infant to sleep or just lay him down? _____

Describe naptime routine? _____

Does your infant/toddler sleep on his/her back, side, stomach? _____

Does your infant /toddler use a pacifier? Yes/No When: _____

What words or gestures does your child use when sleepy? _____

Does your child go to bed with a bottle___yes ___no. If yes, what is in the bottle?_____

Toilet Training and Individual Plan:

How many wet diapers per day?_____ How often does child have bowel movements?_____

When_____

Any recent changes in urine or stool?_____

Explain:_____

Has the toilet/potty been introduced at home?___yes ___no

What is the method and what are the words used? _____

Does your child use a toilet or potty chair? _____

What signals/gestures does your child use to show he/she has to go potty? _____

Does your child have any fears, concerns, special needs, or equipment regarding toileting? _____

Plan at Center: Staff Responsibility	**At Home:** Parent Responsibility
_____	_____
_____	_____
_____	_____
_____	_____

Other Services: _____

_____

_____

Parent Signature	Staff Signature	Date	Next Update
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____