

# 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: \_\_\_\_\_

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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.*

## 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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### 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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