Happy Minds Kids Academy
Infant/Toddler Service Needs Plan

Child’s Name _________________________________ Date ________________

Feeding:
Does your child drink/eat: ☐ Formula ☐ Baby Food ☐ Breast Milk ☐ Finger Foods

Formula brand names: ____________________________________________________________

Consistency: ___________________________________________________________________

Foods liked: ___________________________________________________________________

Foods disliked: __________________________________________________________________

Any known ALLERGIES __________________________________________________________

If your child is on liquids only, at how many months will finger foods be introduced? _______


Please describe your child’s eating habits: __________________________________________________________________

How does your child prefer to be held while drinking a bottle? _________________________

How much does your child usually eat/drink at one feeding? ___________________________

Do you usually burp your baby? ______

Napping

Does your child prefer to sleep on his/her ☐ back, ☐ tummy, ☐ side?

☐ With a pacifier? ☐ Without a pacifier?

When are naps taken and how long?

Morning Naps: _______/_______ _______/_______

Afternoon Naps: _______/_______ _______/_______

Are there any other things regarding your child you would like us to know?

___________________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

Parent’s Signature ___________________________ Date ________________