New Beginnings Child Development Center
Infant Monthly Care Plan

Childs Name: _____ Date of Birth: _____ Age: _____months

Changes at Home?

_____

_____

Diapering and Toileting: D you use powder/ointment on your child? YES NO Brand? _____

Feeding Instructions: Does your child take a bottle? YES NO Type of Bottle? _____

Does your child hold the bottle? YES NO ATTEMPTING

Do you warm your child's bottle? YES NO

My child Eats/ Drinks:

			TYPE(S)	AMOUNT/ HOW OFTEN
FORMULA	**YES**	**NO**		
JUICE	**YES**	**NO**		
CEREAL	**YES**	**NO**		
STAGE 1	**YES**	**NO**		
STAGE 2	**YES**	**NO**		
STAGE 3	**YES**	**NO**		
TABLE FOOD	**YES**	**NO**		
SNACKS	**YES**	**NO**		

FOOD LIKES: _____FOOD DISLIKES: _____

Any allergies? If yes, please describe symptoms to watch for:_____

_____

Does your child take a pacifier? YES NO When?_____

Changes and comments:

_____

_____

Your child will be placed on his/her back for sleep unless we receive a note from your physician stating that it would be best for him/her to sleep on his/her stomach.

Sleeping Schedule (changes and comments)

_____

_____

Any other helpful information (Transitions, Exploration and play)

_____

_____

_____ _____

Parents Signature Date

"Where Leaders of Tomorrow Learn and Play Today!"