Individual Activity Plan & Feeding Schedule

Child's Full Name: _____ D.O.B: _____

Primary Child Care Staff Assigned: _____ Shift/Time: _____

Circle type(s) of liquids you are currently offering your child:

Breast Milk Milk Formula Jucie Water

How much/how often: _____

Do you offer cereal with formula? ___yes ___no: How much/often: _____

Do you mix cereal with fruit/vegetables: __yes __no: How much/often: _____

List Below any foods other than milk/formula that are offered to your baby:

Type of food: Amount of food: How often:

_____

_____

Circle how your child usually eats these foods:

Spoon-fed Uses Fingers Self-spooned Other_____

Does your child have difficulty eating? ___yes ___no (Spits up, chokes, allergies) other _____

What time does your child usually nap? _____am _____pm For how long: _____

How does your child like to fall asleep/nap? _____

(We must nap/sleep infants on their backs unless we have a doctor's note on file to use restrictive devices; wedge, roll, strap, etc.)

All children in our infant/toddler room sleep in a crib until age 2

What are some things your child likes to do? _____

Expected Diapering Schedule: _____

Please list a daily schedule of what your child does during the day_____

_____

Please list any other information we need to know about your child _____

_____

(If you need more space, please note on back of this page)

Parent Signature: _____ Date: _____