The Children’s Center at Caltech

Infant Needs and Services Plan

Updated quarterly

Child’s Name: ________________________________
Age: _______________________________________

I. Individual Feeding Plan

(A) Physician’s instructions to special diet or feeding:
________________________________________________________________________
________________________________________________________________________

(B) Feeding Schedule: Approximate times-
________________________________________________________________________
________________________________________________________________________

(C) Breast milk or Formula: Circle one that applies
Name of formula: _________________________

(D) Schedule for introduction of solid and new foods
________________________________________________________________________
________________________________________________________________________

(E) Food Consistency: (Circle which apply)
Puree (liquidly) Puree (thick) Chunky Small Pieces

(F) Food Likes/Dislikes:
________________________________________________________________________
________________________________________________________________________
(G) Food Allergies:

_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

(H) Schedule for introduction of cups and utensils:

_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

II. Toilet Training Plan: (if applicable)

_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

III. Services needed by infant that are not provided by the CCC Program; any special exercises needed for infants with physical disabilities?

_________________________________________________________________________

IV. Parent Conferences will be conducted quarterly. Future dates listed below:

1. __________________________ (Intake)
2. __________________________
3. __________________________
4. __________________________

Please update this form if there are any medical changes or after newly introducing foods with your child. This form will be in your child’s file. Ask your Primary Caregiver or contact your Lead.

Director’s Signature __________________________________________

Lead Teacher Signature _________________________________________

Parent Signature _____________________________________________

Today’s Date _________________________________________________