Infant Needs and Services Plan

Bergamo Montessori at Serrano

4521 Serrano Parkway, El Dorado Hills, Ca 95762 (916) 358-3835

Lic # 093621256

Date:

Name of child: ________________________________ Date of birth: ______________

Home phone: __________________________ Work phone: ____________________

FEEDING PLAN

Food allergies:

____

What type of reaction can be expected?

____

Breast fed? ____ yes ____ no How often? _________________________________

Bottle fed? ____ yes ____ no How often? ___________________________________

Formula: _______________________________ Amount: _______________________

When was bottle introduced?

____

Holds own bottle? ____ yes ____ no Position while feeding:____________________

Temperature of liquid? ________ warm ________ room temp. ________ cold

Solids?

_____ yes _____ no __________ strained __________ junior __________ finger foods

Solids now in diet?

__________ cereal ______________ vegetables _______ meat ______ fruit

Usual amount of item eaten:

____

Temperature of foods: __________ warm __________ room temp. __________ cold

Feeds self? ______ yes _____ no _______ needs help

What liquid served with meals? ____

_____ in a bottle _____ in a cup ______ needs help with a cup/bottle

Food likes:

____

Food parents/physicians DO NOT want child to have:

____

____

TOILETING PLAN

Type of diapers: _____ cloth _____ disposable

Creams, ointments, powders: Brand: _________________________ Times: _________________

Are bowel movements regular? ____ yes ____ no

Time? ____________________ Number? _________________ Type: _____________

Word used for movement: _______________________ Urination: _________________

Potty training? _____ yes _____ no (Boys): _____ sit _____stand

If boy sits: _____ frontward _____ backward

Use potty chair? _____ yes _____ no Regular toilet? _____ yes _____ no

Needs to be reminded? _____ yes _____ no How often? ______________________

Needs help? _____ yes _____ no

INDIVIDUAL SLEEP PLAN

Nap schedule: Times: _________________________ Duration: __________________

Favored sleep position: ____

At what age did your child roll from back to stomach? ___________________________

_____ Sleep problems _____ nightmares _____ breathing difficulties

Other, please explain:

____

Does child take to bed: ______ blanket ______pacifier ______ bottle __________ other

If bottle, what liquid? ____

GENERAL

What type of activities does your child enjoy?

____

____

How is your child comforted?

____

At what age did your child:

Sit with assistance: ____

Crawl: ____

Walk: ____

Say first word: ____

Siblings? ______ yes ______ no If so, what are their names and ages?

____

____

Extended family members living with the child?

____

Other people that your child has regular contact with (babysitter, friends etc.)?

____

____

What is your estimated drop off time? _________________ Pick up? ______________

Any general questions regarding Montessori philosophy?

____

____

SPECIAL NEEDS

Does your child require any special attention/assistance? Please explain:

____

____

____ ___________________

Parent Signature Date

____ ___________________

Teacher Signature Date