Beit Yeladim Infant Center

Needs and Services Plan

Date of Initial Plan: _____ Date of this Update: _____

The purpose of this form is to help us gain a better understanding of your child. Please feel free to add any information which you think might be helpful. Do not feel obligated to complete questions of which you are unsure. When you have the intake interview you will probably want to discuss some of these items.

<table>
<tr><td>Child's Name</td><td>Nickname</td><td>Height</td><td>Weight</td><td>Birthdate</td><td>Birthplace</td></tr>
<tr><td colspan="3">With whom does your child live?
❑Mother when?
❑Father when?
❑Other who? when?</td><td colspan="3">Is your child toilet-trained?
❑yes ❑no ❑in process
How does your child indicate a need to use the toilet?</td></tr>
<tr><td colspan="3">Siblings who live with your child:
<u>Names</u> <u>Ages</u></td><td colspan="3">Does your child need help in..
❑dressing ❑undressing ❑using a toilet
Does your child have a room alone?
❑yes ❑no
If not, who shares the room?</td></tr>
<tr><td colspan="3">Siblings who <u>do not</u> live with your child:
<u>Names</u> <u>Ages</u></td><td colspan="3">Does your child have any special fears?
Does your child have any special problems?</td></tr>
<tr><td colspan="3">Does your child visit grandparents often?
❑yes ❑no ❑deceased</td><td colspan="3">Has your child ever been tested for a learning disability or developmental delay?
❑yes ❑no</td></tr>
<tr><td colspan="3">What are the grandparents called?</td><td colspan="3">Does your child have any allergies?
❑yes ❑no</td></tr>
<tr><td colspan="3">Other people your child sees frequently:</td><td colspan="3">Does your child require ongoing medications?
❑yes ❑no</td></tr>
<tr><td colspan="3">Has your child been cared for by anyone other than a parent? ❑yes ❑no</td><td colspan="3">Does your child have any history of
• vision or eye problems? ❑yes❑no
• hearing or ear problems? ❑yes❑no
• speech problems? ❑yes❑no</td></tr>
</table>

Beit Yeladim Infant Center

General Information

Do you have any concerns about how you child will adjust to our program?

Is there anything special we should know about your child or your family? (eg recent move, change in family size)

What do you hope your child will gain from the experiences at the Beit Yeladim?

Sleeping

What is your child's current daily sleeping schedule?

Morning wakeup: Evening bedtime: Naps:

Is your child sleeping through the night?

If not, when does child usually wake up at night?

Are there any special ways to help your child sleep?

What position does the child lie in to sleep?

NOTE: To prevent SIDS, the American Academy of Pediatrics recommends that infants not be placed on their stomachs to sleep.

Social/Emotional

What upsets or frightens your child?

What does your child find soothing or comfortable?

How is your child now reacting to strangers?

Does your child ❑use a pacifier? ❑suck a thumb?

Feeding

Is your child using a ❑cup? ❑bottle? ❑both?

Are you breast-feeding your child? ❑yes ❑no

If yes, at what times?

Will you be providing us with expressed milk? ❑yes ❑no

What are the times your child is now receiving a bottle?

How many ounces at each bottle feeding?

Is your child taking ❑formula ❑whole milk ❑other:

Give any special instructions for preparing formula:

Are there any other special instructions concerning bottle-feeding your child?

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Feeding

Is your child now on baby food or table food?

List foods your child is now eating:

Vegetables:

Fruits:

Meats:

Juices:

Is your child now eating finger foods? ❑yes ❑no

If yes, please list:

List any other foods your child is now eating:

How is your child fed? ❑held in lap ❑high chair ❑other:

Eating schedule:

Time	Food/Drink	Amount	Instructions

Does your child have a history of colic? ❑yes ❑no

Cognitive Development

Where does your child like to spend his/her waking hours? (eg crib, playpen, crawling on floor)

What toys and activities make him/her happy?

Has your child begun to talk. ❑yes ❑no What words?

Physical Development

Is there anything about your child's physical development that we should know?

Elimination/Diapering

When does your child usually have bowel movements?

Has your child begun potty training? ❑yes ❑no

If yes, describe his/her routine.

What does your child call a bowel movement? Urination?

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Does your child have diaper rash frequently? ❑yes ❑no
Which of the following diapering products do you use? ❑oil ❑powder ❑lotion ❑other:
What type of diaper do you currently use? ❑disposable ❑cloth ❑pull-up Size:
Does your child wear plastic pants? ❑always ❑sometimes ❑never

Other Information for the Teacher

Parent's Signature: _____

Director's Signature: _____