

DESERT CHRISTIAN ACADEMY  
INFANT/TODDLER NEEDS & SERVICES PLAN

<b>Child's Name:</b>	<b>Date of Birth:</b>	Today's Date:
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Please circle or write your answers to the following questions.

<p>1. Is your child on a special diet? Yes/No If yes, what diet? _____ _____</p> <p>2. Is your child allergic to any foods? Yes/No If yes, what? _____ _____</p> <p>3. Are there any foods your child should not eat for medical, religious, or personal reasons? Yes/No If yes, what? _____ _____</p> <p>4. Has there been a big change in your child's appetite in the last month? Yes/No If yes, what? _____ _____</p> <p>5. Does your child ever eat things like plaster, dirt, clay, paint chips or other inedible objects? Yes/No _____ _____ _____</p>	<p>6. Does your child take a bottle? Yes/No During the day ____ At night _____ What do you put in the bottle? _____ What type of bottles and nipples are used at home? _____ _____</p> <p>7. Is the bottle warmed? Yes/No</p> <p>8. How many meals does your child eat each day? _____</p> <p>9. How many times a day does your child eat a snack? _____</p> <p>10. Special food likes and dislikes: _____ _____ _____ _____ _____ _____</p>
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**Feeding Information:**

Food or Drink	Meal	Type	How Much	How Often
Milk	B L D S			
Formula	B L D S			
Dairy Products	B L D S			
Vegetables	B L D S			
Fruits	B L D S			
Meats & Proteins	B L D S			
Drink	B L D S			
Table Foods	B L D S			
Other	B L D S			

My child uses a:    Bottle    Cup    Fork    Spoon

What are your child's favorite snacks? \_\_\_\_\_

Any additional comments or instructions regarding feeding or diet? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Sleeping Information:**

What time does your child get up?    What time does your child go to bed? \_\_\_\_\_

Does your child sleep during the day?    Yes/No    If yes, when & for how long \_\_\_\_\_

Does your child sleep alone or with others \_\_\_\_\_

Does your child sleep in a crib or toddler bed? \_\_\_\_\_

How do you usually put your child to sleep (i.e. singing, rocking, etc.)? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Toileting Information:**

How many wet diapers a day?    How often does your child have bowel movements? \_\_\_\_\_

When? \_\_\_\_\_ Any changes in urine or stool? \_\_\_\_\_

Explain: \_\_\_\_\_

Has use of toilet been introduced at home?    Yes/No    If yes, how? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does your child have any fears or concerns regarding toileting? \_\_\_\_\_

Do you wish for your child to use disposable diapers or training pants? \_\_\_\_\_

Do you wish for any changes to be made for your child regarding our toilet training plan?

If yes, explain:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Additional comments or instructions: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Discipline Information:**

Do you believe that children need discipline? \_\_\_\_\_

Do you believe the school and home should be in agreement regarding discipline? \_\_\_\_\_

Are you in agreement with CSOD's policy on discipline? \_\_\_\_\_

Specifically, do you agree with the "No Violence" policy stating that a child must not hurt himself/herself, must not hurt others, and must not damage property? \_\_\_\_\_

What method of behavior control do you use at home? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What forms of positive reinforcements work at home? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What forms of negative reinforcements work at home? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do both parents agree in how to discipline?

\_\_\_\_\_ If not, how do parents' discipline views differ? \_

\_\_\_\_\_

\_\_\_\_\_

Does your child receive instruction and correction easily? \_\_\_\_\_

\_\_\_\_\_