Sacramento County Early Head Start
Infant/Toddler Needs and Services Plan

Child's Name: ____	
Child's Date of Birth: ____________	**Age at enrollment**: __________________

Before completing the Needs and Services Plan, please fill out a child health history and infant nutrition assessment.

Sleeping/Napping

1. What time does your child get up? ____

____

2. What time does your child go to bed? ______________________________________

____

3. Does your child sleep during the day? If yes, when & for how long? ______________

____

4. Does your child sleep alone or with others? _________________________________

____

5. How do you usually put your child to sleep (e.g. singing, rocking, etc.)?

____

____

Diapering/Toileting

6. Do you use disposable or cloth diapers? ____________________________________

____

(over)

7. What word do you/your child use for “urination”? ______________________________

____

8. What word do you/your child use for “bowel movement”? ______________________

____

9. Individual toilet training plan (if applicable): ___________________________________

____

<u>Individual Feeding Plan:</u>

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____

Additional comments/Instructions from parents: ______________________

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If child has a disability, please refer to the IFSP for the plan for the child. Each parent/guardian will receive a minimum of two home visits and two conferences each year.

____

Parent Signature Date

____

Staff Signature Date

Copy to parent/Copy to file