ROCKING HORSE ACADEMY
Child Information / Infant Care Plan

Today's Date ______/_______/_______

Date Updated ______/_______/_______

CHILD INFORMATION

Child's Name:	Date of Birth: / /
Nickname(s):	
Primary Contact:	Secondary Contact:
Cell Phone:	Cell Phone:

FEEDING

BOTTLES MUST BE EQUAL AMOUNTS, LABELED WITH CHILD'S FIRST NAME AND LAST INITIAL AND DATED.

Child's diet includes (check all that apply):

- Breast Milk ☐
- Formula ☐
- Whole Milk ☐
- Other Milk ☐
- Baby Foods ☐
- Strained Foods ☐
- Table Foods ☐
- Water ☐

Formula Brand / Other Milk Type: ________________________

Desired Warmth:

- Room Temp. ☐
- Very Warm ☐
- Tepid ☐
- Cold ☐
- Bottle Warmer ☐
- Microwave ☐

Bottle Amount: _____________oz.

FEEDING SCHEDULE	APPROX. TIME	TYPES AND APPROXIMATE AMOUNT OF FOOD (EX. BABY FOOD ½ JAR, BOTTLE, ¼ BANANA ETC.) Label all containers w/first name, last initial and date.
Breakfast		
AM Snack		
Lunch		
PM Snack		
Dinner		

SLEEPING

CHILD MUST SLEEP ON BACK UNTIL ABLE TO TURN OVER ON THEIR OWN. RHA FOLLOWS *SAFE-TO-SLEEP* STANDARDS REQUIRED BY LICENSING AND RECCOMENDED BY THE SIDS ALLIANCE.

Nap	Approx. Time
1st Nap	
2nd Nap	
3rd Nap	
4th Nap	

Does your child sleep in a sleep suit/sack? Yes ☐ No ☐

Does your child take a pacifier? Yes ☐ No ☐

If so, when? ____

Sleeping Habits? ____

DIAPERING

Do you give permission for diaper cream to be used for diaper rash? Yes ☐ No ☐

Brand/Type: ____

Do you use baby powder when changing your child? Yes ☐ No ☐

(PLEASE CONTINUE ON BACK)

ADDITIONAL CHILD INFORMATION

Does your child have a history of colic? ______________________________

What comfort measures are used with your child? ______________________________

____

Previous experience child has outside the home: Babysitter ☐ Group Care ☐ Family ☐

Childs Response? ______________________________

What languages are spoken in the home? ______________________________

Does your child share a room? Yes ☐ No ☐ If yes, with whom? ______________________________

Sibling(s)? ____________________ Age(s)? ____________________

Birthmarks: ______________________________

Allergies: ______________________________

Special Needs or Concerns: ______________________________

____

Medical Conditions: ______________________________

____

Any Additional Information: ______________________________

____

____

Parent/Guardian Signature ______________________________ Date: ________/________/________

EXAMPLES OF HOW ITEMS ARE REQUIRED TO BE LABELED:

Bottles: equal amounts, first name, last initial date.
Bottle Cap: Initials

Diapers: initials on every diaper

All Food Containers (including packaged/jar foods): First name, last initial and date

THIS FORM MUST BE REVIEWED/UPDATED EVERY 30 DAYS