

Mechanicsburg Learning Center
626 Williams Grove Road
Mechanicsburg PA 17055
717-697-6379



Infant Personal Care Plan

Date: _____ Enrollment Date: _____
Child's Name: _____ Child's Birthdate: _____
What would you like us to call your child? _____
Parent/Guardian Name: _____
Parent/Guardian Name: _____
Name of person completing form: _____
Primary Caregiver: _____

Family Information

In the columns below list the names of family members residing with your child. Please include siblings, extended relatives, and pets. For each person listed, provide the name the child uses to address that individual and include ages of siblings.

Name	How child addresses the individual	Age

If parental custody is shared, describe the custody arrangements: _____

Please tell us about cultural family customs, rituals, or traditions that will help us make your child's experience more meaningful, including languages spoken at home: _____

Developmental History

Age child Began...

Sitting: _____ Crawling: _____ Standing: _____ Walking with support: _____

Walking independently: _____ Cooing: _____ Babbling: _____

Saying audible words: _____ Saying 2-3 simple sentences: _____

Do you have developmental concerns about your child? If so, please explain: _____

How does your child communicate his/her needs: _____

Child's Health

List medications regularly taken and conditions requiring them: _____

Describe serious illnesses or hospitalizations: _____

Describe special physical conditions, disabilities, allergies, or concerns: _____

Does your child have any special needs: _____

Nutritional Practices and Routines

How is your child fed (check all that apply): _____ Breastmilk _____ Bottle _____ Cup

List special dietary requests or restrictions: _____

Have solid foods been introduced? _____ Yes _____ No

If Yes, please identify which foods: _____

Food likes and eating preferences: _____

Child eats with: _____ Spoon _____ Fork _____ Fingers

Child is fed in: _____ Highchair _____ In arms _____ Other- describe _____

Additional information: _____

Sleeping Routines

Pre-nap routines/rituals: _____

At home child sleeps in (check all that apply): _____ Bassinet _____ Crib _____ Bed

Child's typical waking behavior/routine: _____

Special sleeping concerns: _____

Comforting Child

Position children prefers to be held: _____

Security object (if any): _____

Name child uses for object when needed: _____

Does your child use a pacifier: _____ Yes _____ No If yes, when? _____

Describe how adults comfort your child: _____

Diapering/Toilet Routines

Words used for urination: _____

Words used for bowel movement: _____

Social Relationships

Has your child had any previous childcare experience? If yes, please describe. Also describe how it met, or did not meet your expectations: _____

How does your child react to new situations and new children and adults: _____

Child's favorite toys and activities: _____

Does your child have any fears? Explain: _____

Additional Parent Information

To help us care for you child as an individual, please explain your parenting philosophy: _____

Is there additional information you feel is important for the staff to know about your child or family: _____

What do you hope your child can achieve through this childcare experience: _____

Sections of this personal care plan will be updated every three months or sooner if requested by a parent/guardian.

Parent/Guardian Signature: _____ Date: _____

Staff Signature: _____ Date: _____

Update Date: _____ Parent Intials: _____ Staff Initials: _____

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