LOYOLA MEDICINE
Gottlieb Memorial Hospital
A Member of Trinity Health

Gottlieb Child Development Center
905 W. North Avenue, Entrance #17
Melrose Park, IL 60160
708-538-6871

Infant Personal Care Plan
Developmental History Form

Today's Date: _____ Date of Enrollment: _____

Child's Name _____ Date of Birth: _____ Age: _____

Date of Last Physical: _____

What would you like us to call your child? _____

Parent/Guardian Name: _____

Parent/Guardian Name: _____

Name of Person Completing Form: _____

Primary Caregiver: _____

Classroom: _____

Family Information

In the columns below, list the names of family members residing with the 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 this individual?	Age

Please list the words used in your language corresponding to the words in English. Include additional words in the blank columns if needed.

I'll take good care of you	
I see that you are crying	
Let's change your diaper	
I like your smile	
It's time for your bottle	
Time to eat	
Time for your nap	
Mommy will be back	
Daddy will be back	

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	_____	Cooing
_____	Crawling	_____	Babbling
_____	Standing	_____	Saying audible words
_____	Walking with Support	_____	Saying 2 or 3 simple sentences
_____	Walking Independently		

Do you have developmental concerns about your child?

_____

_____

_____

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, disabilites, allergies, or concerns:

_____

_____

_____

Does your child have a special need?

_____

_____

_____

Explain special services and accomodations, which are different from those provided by the center's routine program (i.e. exercises, equipment, materials, or special services personnel):

_____

_____

Note: For documented medical allergies an Allergy Health Care Plan completed by the child's medical provider is required.

Nutrition Practices and Routines

How is your child fed? Check all that apply: ☐ Breast ☐ Bottle ☐ Cup

Provide your child's feeding details in the chart below.

	Brand	Amount	Preferred Time of Day Given
Formula/Milk			
Breast Milk			
Juice			

If your baby is exclusively breast fed, please outline your daily plan:

_____

_____

_____

If your baby is breast fed or receiving expressed breast milk, how can we support you?

_____

_____

_____

List special dietary requests and restrictions:

_____

_____

_____

Have solid foods been introduced? ☐ Yes ☐ No If yes, please identify:

_____

_____

_____

Food likes and eating preferences:

_____

_____

_____

Child eats with: ☐ Spoon ☐ Fork ☐ Fingers

Child is fed in: ☐ High chair ☐ In arms ☐ Bouncy seat ☐ Other: _____

Preferred time of day to feed child: _____ AM _____ AM _____ PM _____ PM

Additional information:

_____

_____

_____

Sleeping Routines

Pre-nap routines/rituals:

_____

_____

_____

Number of naps daily: _____ | From: _____ To: _____ From: _____ To: _____ From: _____ To: _____

Preferred sleep position: _____

At home, child sleeps in: ☐ Bassinet ☐ Crib ☐ Bed

Child's typical waking routine:

_____

_____

_____

Special sleeping concerns:

_____

_____

_____

Note: Gottlieb places infants to sleep on their backs in crib unless a waiver has been signed by the parents and the child's physician, stating that the child should be placed in a position other than his/her back and if allowed by the state licensing agency. Following the recommendation of the American Academy of Pediatrics, soft items such as bumpers, stuffed animals (including pacifiers with a stuffed animal attached), blankets and quilts are not allowed in cribs. The use of sleep or swaddle sacks are recommended for naptime; however, there may be restrictions on the use of and type of these by the state licensing agency.

Comforting Child

Position child 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 can comfort your child: _____

_____

_____

Diapering/Toileting Routines

Please check which type of diapers you will provide: ☐ Disposable ☐ Cloth

Words used for urination: _____

Words used for bowel movement: _____

_____

_____

Social Relationships

Has your child had any experience with group care? If yes, please describe:

How does your child react to new situations and new children and adults?

Has your child had previous child care experience? If yes, explain how it met, or did not meet, your expectations?

Child's favorite toys and activites:

Does your child have any fears? Explain:

Additional Pertinent Information

To help us care for your 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 as a family hope to get out of this child care experience?

Sections of this Personal Care Plan will be updated every 3 months or sooner if requested by a parent/guardian.

Parent/Guardian Signature: _____ Date: _____

Staff Signature: _____ Date: _____

Date of change:		Parent Initials:		Staff Initials:	
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Date of change:		Parent Initials:		Staff Initials:	
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