



Learn And Play School Needs and Services Plan

Today's Date: _____ Date of Enrollment: _____ Classroom: _____

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

Parent/Guardian Name: _____

Parent/Guardian's Contact #: _____

The next update for _____'s Needs and Services plan is
scheduled for (M/D/Y): ____/____/____ or will be conducted as needed.

Parent Signature: _____ Date: _____

Director Signature: _____ Date: _____

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Date Plan reviewed/updated: _____ Parent/Guardian's initials: _____ Director Initials: _____

Comments: _____

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Comments: _____



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DIAPERING/TOILETING ROUTINES

For children who are beginning to potty train at home, parents must provide two complete sets of extra clothes (socks, shirt, and pants). Parents must also provide five pairs of underwear/panties in addition to Pull-Ups (with side Velcro) to keep on hand at school. We understand how important it is for children to have a successful experience when it comes to potty training. Our teaching staff will do their best to work in collaboration with parents when children are ready to start the potty-training process. LAPMS teachers will assist children with potty needs every two hours, or as needed. After the second potty accident, staff will change the child into Pull-Ups and will continue to take children to the bathroom every two-hour basis or as needed during the remainder of the day.

Is your child toilet trained? ☐ Yes ☐ No ☐ Urination ☐ Bowel ☐ Both

If yes, when did you begin: _____

Does our child have accidents? ☐ Yes ☐ No If yes, how often/when? _____

Does your child wear diapers during the day? ☐ Yes ☐ No

Does your child wear diapers when napping? ☐ Yes ☐ No

Words used for urination: _____

Words used for bowel movement: _____

Are bowel movements regular? ☐ Yes ☐ No ☐ How often/when? _____

What is used for home toileting? ☐ Potty chair ☐ Potty seat ☐ Regular seat ☐ Explain: _____

How can we support toilet learning at school? _____



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EATING AND FEEDING

Liquids: ☐ Breastmilk ☐ Formula ☐ Water

If your child is drinking formula, what type: _____

Bottle Type: ☐ Disposable ☐ Reusable Flow Level: _____

Bottle Temperature: ☐ Warm ☐ Room ☐ Temperature ☐ Cold

Feeding Frequency: _____ Number of Ounces: _____

Does your child drink from a sippy cup? ☐ Yes ☐ No

Solids: ☐ Purees ☐ Finger Foods ☐ None (Yet)

(Infant ONLY) When or how frequently does your child eat: _____

(Infant ONLY) Plan for introduction of solids: _____

List any strong preferences or known allergies and their symptoms: _____

Can your child eat any or all center snacks? ☐ Yes ☐ No

_____ I understand that I may replace the planned snack with a comparable alternative.

_____ I understand that I must label all bottles and containers with my child's name and the date, and that glass containers are not permitted.



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INFANT SLEEPING / INDIVIDUAL INFANT SLEEPING PLAN

LIC 9227 - Individual Infant Sleeping Plan

This section is to be completed for infant sleep information and used together with the applicable LIC 9227 Individual Infant Sleeping Plan. The completed LIC 9227 and any required supporting documentation shall be maintained in the infant's file.

Date of Sleeping Plan: _____

A. SLEEPING ENVIRONMENT AND ROUTINE

At home, the infant sleeps in: ☐ Crib ☐ Play Yard ☐ Other (specify): _____

Infant's usual sleeping hours: _____

Average length of daytime nap(s): _____ minutes / _____ hours

Does the infant use a pacifier? ☐ Yes ☐ No ☐ Sometimes

If yes, brand: _____

B. INFANT'S ABILITY TO ROLL - PARENT / AUTHORIZED REPRESENTATIVE

My child, _____, is able to roll from back to stomach and stomach to back beginning: _____ / _____ / _____.

Authorized Representative Signature: _____ Date: _____

C. INFANT'S ABILITY TO ROLL - CHILD CARE OBSERVATION

Provider observed the infant is capable of rolling from back to stomach and stomach to back.

☐ Yes ☐ Not Yet Observed

Provider Signature: _____ Date: _____

Authorized Representative Signature: _____ Date: _____

(Authorized representative signature to be completed no later than the next business day following provider observation.)

D. SAFE SLEEP INFORMATION

The center will place the infant on their back for sleep unless a licensed physician has provided a medical exemption with instructions for an alternate sleeping position. If the infant independently rolls from back to stomach and stomach to back, the infant may assume their preferred sleep position after being placed on their back.

E. MEDICAL EXEMPTION

Does the infant have a medical exemption? ☐ Yes ☐ No

If yes, attach the licensed physician's written instructions. The documentation must include:

- Instructions on how the infant shall be placed to sleep, including sleep position.
- Duration the exemption is to be in place.



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- Licensed physician's contact information.
- Licensed physician's signature and date of signature.

Required medical exemption documents must be attached to LIC 9227 and maintained in the infant's file.

F. AUTHORIZED REPRESENTATIVE CERTIFICATION

I certify that the information provided regarding my child's sleeping routine, ability to roll, and medical exemption status is complete and accurate to the best of my ability.

Authorized Representative Signature: _____ Date: _____

OTHER

Does your child require any special accommodations not covered by this plan?

Do you have any additional requests or instructions for the care of your child?
