Little Acorns
Learning Center

Infant Care Plan

Child's Name: _____ Date of Birth: _____

Completed by: _____ Date: _____

Completing this form helps us understand your child's schedule and needs while in our care. We understand that schedules change as children grow and will request updates periodically.

Typical drop off time: _____ pick-up time: _____

Bottles: ☐ Formula ☐ Breastmilk ☐ Other _____ Warmed? ☐ Y ☐ N

Breakfast:

Time: _____ Bottle amount: _____ Baby food: _____

AM Snack:

Time: _____ Bottle amount: _____ Baby food: _____

Lunch:

Time: _____ Bottle amount: _____ Baby food: _____

PM Snack:

Time: _____ Bottle amount: _____ Baby food: _____

Any known allergies: _____

Diaper cream: ☐ Every change ☐ As needed ☐ Not used

What does your child's sleep schedule look like?

_____

Anything else you would like to share?