Infant Daily Schedule

Student Name _____ DOB _____ Current Age (in months) _____

Please return before your child's start date, and then monthly, via mail or email to: EGEDirector@suescuela.com

****At this stage in an infant's life their schedules are changing so frequently, so for us to stay consistent at school with what you are doing at home, please send an updated version of this plan to the Director as often as your child's schedule changes. ****

Bottles:

Is your child drinking bottles? (Please circle) YES NO

If yes, is your child drinking breast milk, formula, or whole milk? _____

How many ounces does your child drink at each feed? _____

*(Please note that per EEC regulations each bottle sent in should have only enough milk/formula for one feed. Bottles will only be offered for *one hour* once it is started, and any unused milk will be sent home) *

How often is your child drinking bottles? _____

How often, if at all, does your child typically need to be burped during a bottle? _____

Does your child spit up after feeding? YES NO

Does your child drink water from a sippy cup? YES NO How often? _____

Meals:

Is your child eating food? (Please circle) YES NO

If yes, is your child eating only pureed food, a mix of pureed food and finger foods, or only finger foods?_____

Does your child have any known food allergies/sensitivities/aversions/preferences? YES NO

If yes, please explain: _____

What time of day, or how frequently does your child eat meals? (i.e. at 8:00, 12:00 and 3:00; every 4 hours; 1 hour after bottle, etc.) _____

Any other specific notes about bottles and/or meals: _____

_____

SELA
The International Private School

Napping:

How often does your child nap? _____ How long is a typical nap? _____

Does your child sleep with a pacifier? YES NO

*(Please note that per EEC regulations pacifiers must be free from lanyards, cords, stuffed animals, or any other embellishments) *

Does your child use a sleep sack, sleep suit, or nothing when napping? _____

Are there specific nap routines at home? _____

_____

Where does your child nap at home? _____

How does your child fall asleep? (rocked, on their own, etc.) _____

General Schedule

Please give an overview of your child's daily schedule:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signature of Parent _____ Date _____