INFANT FEEDING PLAN

Child's full name_____ Date_____

Date of birth_____

Does child take bottle? Yes [ ] No [ ]
Is the bottle warmed? Yes [ ] No [ ]
Does the child hold own bottle? Yes [ ] No [ ]
Can the child feed self? Yes [ ] No [ ]

Does the child eat: (Check all that apply)
Strained foods [ ] Whole milk [ ]
Baby foods [ ] Table foods [ ]
Formula [ ] Other [ ]
Breast Milk [ ]

What type of formula used? _____

Amount of formula/breast milk to be given? _____

Updated amounts of formula/breast milk: _____ Date: _____
Amount: _____ Date: _____
Amount: _____ Date: _____
Amount: _____ Date: _____
Amount: _____ Date: _____

Does the child take a pacifier? Yes [ ] No [ ] If yes, when?_____

_____

Food likes _____

Dislikes _____

Allergies? (Include any premixed formula)_____

FORMULA/ BREAST MILK			FOOD		
TIME	AMOUNT	TYPE	TIME	AMOUNT	TYPE

Instructions for the introduction of solid foods_____

_____

Any updated instructions regarding adding new foods or other dietary changes, please list as needed. _____

_____

_____

PARENTS' SIGNATURE: _____ **Date:** _____