



INFANT FEEDING PLAN

Child's name: _____

Birth Date: _____

Type of Formula: _____

Amt. Given _____

How often: _____

Type of Juice: _____

Amt. Given _____

How often: _____

OFFICE USE ONLY

Does your child take a bottle? Yes No

Is Bottle warmed? Yes No

Does child hold own bottle? Yes No

Does child require certain bottle type? Yes No

Uses Daycare Formula

Uses Daycare Bottles

Brings own Formula

Brings own Bottles

Does child eat.....

Table Food → Meat Vegetable Fruit

Food Likes: _____

Baby Food → Meat Vegetable Fruit

Food Dislikes: _____

Baby Cereal → RICE OATMEAL MIXED

Any Food Allergies? Yes No

Explain: _____

Child's Schedule:

Breakfast: Amt. of Food _____ Bottle Amt./Type _____

Lunch: Amt. of Food _____ Bottle Amt./Type _____ ▶

Snack: Amt. of Food _____ Bottle Amt./Type _____

Does child take a
PACIFIER? Y N

Signature

Relation to Child

Date