INFANT FEEDING PLAN

Form can be filled out a few days before Starting

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

Please wake up my child if they are sleeping and it is time for them to eat Yes No

Length of time to let my child sleep past their feeding time ____________ minutes

Does the child eat: (Check all that apply)

Strained foods Baby foods Formula Breast Milk Whole milk Table foods Other

What type of formula used? ____

Amount of formula/breast milk to be given? ____

Updated amounts of formula/breast milk:

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 food ____

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

PARENTS' SIGNATURE: ____ Date:______________________