Stepping Stones Academy
...itty bitty steps towards success

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☐ 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:_____