INFANT FEEDING PLAN

Child's Name: _____ Date of Birth: _____

Date Form Completed: _____ Age: _____

Does your child take a 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 your child eat: (check all that apply)

☐ Strained foods ☐ Formula

☐ Baby foods ☐ Breast milk

☐ Table foods ☐ Whole milk

☐ Other:

What type of formula is used? _____

Amount of formula/breast milk to be given: _____

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

_____ Date: _____

_____ Date: _____

Instructions for the introduction of solid foods: _____

_____

Foods likes: _____

Foods dislikes: _____

Does child take a pacifier? ☐ Yes ☐ No If yes, when? _____

Does your child have allergies/known medical conditions (include any premixed formula)? ☐ Yes ☐ No

If yes, please list: _____

NOTE: Your child will be placed on his or her back to sleep unless a written doctor's statement is provided stating otherwise.

CHILD'S SCHEDULE

Breakfast: _____ _____

(approximate time) Type and approximate amount of food

Lunch: _____ _____

(approximate time) Type and approximate amount of food

Dinner: _____ _____

(approximate time) Type and approximate amount of food

Morning nap: _____ Afternoon nap: _____

(approximate time) (approximate time)

Infant feeding plan needs to be updated every three months, or as needed, in regards to adding new foods or other dietary changes with a new parent/guardian signature and date.

_____ _____

Parent/Guardian Signature Date