



Infant Feeding Plan

Personal Information:

Child's Name _____ Date _____

Birth date _____

Food Information:

Does the child take a bottle? Y N

Is the bottle warmed? Y N

Does the child hold bottle? Y N

Can the child feed self? Y N

Does the child eat (check all that apply):

Strained Foods __ Whole Milk __

Baby Foods __ Table Food __

Formula __ Other __

What type of formula is used? _____

Amount of formula to be given? _____

Updated amounts of formula: _____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

Food they like: _____ Dislikes: _____

Instructions for the introduction of solid foods: _____

Any updated instructions regarding adding new foods or other dietary changes, please list as needed along with date: _____

Other Information:

Allergies (include any premixed formula):

Does the child take a pacifier? Y N

When in particular? _____

Child's Schedule:

Breakfast: _____ (Approx. Time) _____ (Types and approx. amounts of food)

Lunch: _____ (Approx. Time) _____ (Types and approx. amounts of food)

Dinner: _____ (Approx. Time) _____ (Types and approx. amounts of food)

Morning Nap: _____ (Approx. Time) _____ (Types and approx. amounts of food)

Verification:

PARENT'S SIGNATURE: _____ Date: _____