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 [ ] Whole milk [ ] Baby foods [ ] Table foods [ ] Formula [ ]
Breast Milk [ ] Other [ ]

What type of formula used?_____
Amount of formula/breast milk to be given?_____
Updated amounts of formula/breast milk:_____Date:_____
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 foods_____

Any updated instructions regarding adding new foods or other dietary changes, please list as needed_____

PARENTS' SIGNATURE:_____ **Date:**_____