Infant Feeding Plan

*Please fill in all boxes/lines and update form as changes in feeding are made.

Child's Name: _____ Date: _____
Birth Date: _____

	Yes	No
Does the child take a bottle?		
Is the bottle warmed?		
Can the child hold own bottle?		
Can the child feed self?		

Does the child eat: (check all that apply)

Strained Foods		Whole Milk	
Baby Foods		Formula	
Table Foods		Other	

What type of formula is used? _____
Note: All bottles must be prepared at home.

	Amount	How Often to be Given	Date
Amount of formula to be given			
Updated amounts to be given			
Updated amounts to be given			
Updated amounts to be given			

Does the child take a pacifier? _____ If so, when? _____

Food likes: _____
Food dislikes: _____

Allergies (including pre-mixed): _____
(Note: this line must be filled out)

Child's Schedule:

	Approximate Time	Types and Approximate Amounts of Food
Breakfast		
Morning Snack		
Lunch		
Afternoon Snack		
Dinner		

Morning Nap Time: _____ Afternoon Nap Time: _____

Instructions for the introduction of solid foods: _____
_____
Any updated instructions regarding adding new foods or other dietary changes, please list as needed:
_____
_____

_____ Date: _____
Parent/Guardian Signature