

Infant Feeding Plan

Child's Name: _____ **Date:** _____

Birthdate: _____

Does the 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 the child eat:

Strained foods _____ Whole Milk _____

Baby Foods _____ Table Foods _____

Formula _____ Other _____

What type of formula is used? _____

Amount of formula to be given? _____

Updated amounts of formula; _____ Date: _____

_____ Date: _____

_____ Date: _____

Does the child take a pacifier? ___ Yes ___ No

When? _____

Food likes: _____ Food Dislikes: _____

Allergies (Please Include any pre-mixed formulas)?

Child's Schedule:

Breakfast: _____
Approximate Time *Types and approximate amounts of food*

Lunch: _____
Approximate Time *Types and approximate amounts of food*

Morning Nap: _____ Afternoon Nap: _____
Approximate Time *Approximate Time*

Instructions for introduction of solid foods: _____

Parent/Guardian Signature: _____ Date: _____