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 [ ] Other [ ]
Breast Milk [ ]

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?______________________________

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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______________________________________

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Any updated instructions regarding adding new foods or other dietary changes, please list as needed. ______________

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PARENTS' SIGNATURE: ________________________________ Date: __________________