INFANT FEEDINING 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? _____

_____

FOOD LIKES _____

DISLIKES _____

ALLERGIES? (INCLUDE ANY PREMIXED FORMULA) _____

FORMULA/BREAST MILK		
TIME	AMOUNT	TYPE

FOOD		
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:

_____

_____

PARENT SIGNATURE: _____ DATE:_____