



Infant Feeding Plan

Child's Name _____ Date _____

Birthday _____

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 Food [] |
| Formula [] | Other [] |

What type formula 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 dislike _____

Allergies- including any premixed formula _____

Child's Schedule

Breakfast _____
Approximate Time _____ Types and approximate amount of food _____

Lunch _____
Approximate Time _____ Types and approximate amount of food _____

Dinner _____
Approximate Time _____ Types and approximate amount of food _____

Morning Nap _____ Afternoon Nap _____
Approximate Time _____ Approximate Time _____

Instructions for the introduction of solid foods _____

As needed, please list updated instructions regarding adding new foods or other dietary changes.

Parent/Guardian Signature _____