INFANT FEEDING PLAN

Child's Full Name____ **Date of Birth** _________________________

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

Does the child eat: *(check all that apply)*

Strained foods	
Baby foods	
Formula	
Breast Milk	
Whole Milk	
Table foods	
Other	

What type of formula used? ____

Amount of formula/breast milk to be given? ____

Updated Amounts of Formula/breast milk to be given:

DATE	AMOUNT	COMMENTS

Does the child take a pacifier? Yes [ ] No [ ] If yes, when?____

____

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____

____

Any updated instructions regarding adding new foods or other dietary changes, please provide as needed. _____________
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PARENTS' SIGNATURE: ______________________________ **Date: ______________________**