NURSERY/INFANT FEEDING SCHEDULE

NAME: _____ DATE: _____

DATE OF BIRTH: _____

ALLERGIES: _____

MEDICAL PROBLEMS: _____

_____

EMERGENCY PHONE NUMBER(S): _____

_____

BRAND OF FORMULA: _____ BOTTLES PER DAY: _____

2% OR WHOLE MILK: _____ BOTTLE OR CUP: _____

BABY FOOD: _____ FRUIT: _____ VEGETABLES: _____

_____

_____

DOES YOUR CHILD EAT TABLE FOOD? _____ WHAT KIND? _____

_____

BREAKFAST: _____ TIME: _____

BOTTLES: _____ TIME: _____

LUNCH: _____ TIME: _____

AFTERNOON BOTTLES: _____ TIME: _____

AFTERNOON SNACK: _____ TIME: _____

OTHER: _____

TYPE OF DISPOSABLE DIAPERS: _____

*** PLEASE LABEL ALL FOODS AND BOTTLES***

Parents: Please let us know when your baby's diet changes (i.e. changing to a different food or formula or going to table food) because we are required by the standard to have you update, in writing, this form as the changes happen.

_____ _____

Parental Signature Date