Infant Care Instructions

Today's Date: _____ **EXPIRES ON: _____**

Child's Name _____ DOB:_____

Breastmilk Y or N

Formula Y or N Type: _____

Warmed? Not at all Slightly Completely

How often does your infant get a bottle? _____

How many ounces? _____

Does your infant eat baby food? Y or N

Cereal? Y or N Types: _____

Fruits? Y or N Types: _____

Veggies? Y or N Types: _____

Meats? Y or N Types: _____

How often? _____

Does your child use a pacifier? Yes No Only When Sleeping

Your infant sleeps best when... Rocked Patted Falls Asleep on Own

Allergies? Y N Unknown _____

Any other information we should know about your infant?

_____

_____

Signature_____ Date _____

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