INFANT FEEDING 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			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 list as needed. _____

_____

_____

PARENTS' SIGNATURE: _____ **Date:** _____

Please complete this form and click the button to the right, or you can save and email this form to: tlrs3045@gmail.com

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