

HEALTH CONSULTANTS FOR CHILD CARE

INFANT DIETARY INSTRUCTION FORM

Child's Name: _____ **Date of Birth:** _____

All foods must be tried at home for 3 – 5 days to observe for allergic reactions.

Please initial and date next to each food to be given at the center.

For combination foods, be sure to sign off on all ingredients. *All food must sized to prevent choking.*

	Initials	Date		Initials	Date
<u>PROTEINS:</u>			<u>VEGETABLES:</u>		
Beef	_____	_____	Avocado	_____	_____
Cheese	_____	_____	Beans	_____	_____
Chicken	_____	_____	Beets	_____	_____
Cottage Cheese	_____	_____	Broccoli	_____	_____
Ham	_____	_____	Carrots	_____	_____
Turkey	_____	_____	Celery	_____	_____
Tofu	_____	_____	Corn	_____	_____
Yogurt	_____	_____	Cucumber	_____	_____
<u>FRUITS:</u>			Garbanzo	_____	_____
Apple	_____	_____	Green Beans	_____	_____
Apricot	_____	_____	Jicama	_____	_____
Banana	_____	_____	Kale	_____	_____
Blueberry	_____	_____	Lentil	_____	_____
Blackberry	_____	_____	Peas	_____	_____
Cherries (pitted)	_____	_____	Potato	_____	_____
Kiwi	_____	_____	Pumpkin	_____	_____
Mango	_____	_____	Spinach	_____	_____
Melons	_____	_____	Squash	_____	_____
Papaya	_____	_____	Yam	_____	_____
Pears	_____	_____	Zucchini	_____	_____
Plums	_____	_____	<u>GRAINS:</u>		
Prunes	_____	_____	Barley	_____	_____
Raspberry	_____	_____	Oatmeal	_____	_____
Strawberry	_____	_____	Quinoa	_____	_____
			Rice	_____	_____
			Wheat	_____	_____

Please check all that apply:

Breast Milk ___ Formula ___ Whole Milk ___ Soy Milk ___ Selected Items-Program Menu ___

I have tried the above foods and give permission for them to be given to my child.
I understand that this list is not inclusive; therefore I give permission for any foods/combinations of foods brought in from home to be given as well.

 Parent/Guardian Signature

 Date

 Parent/Guardian Signature

 Date © HCCC 2020