

TLC Child Care Center

2041 Reed Road Fort Wayne, IN 46815
tlckidsfirst.com

260-424-8852
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Infant Feeding Plan

Child's Name: _____ **DOB** ____/____/____

Bottle Feedings

Formula/Breast milk: _____

Bottle: _____

Nipple: _____

<u>Date</u>	<u>Amount</u>		<u>Frequency</u>		<u>Initial</u>
_____	_____ oz	every ____ hours	or	on demand	_____
_____	_____ oz	every ____ hours	or	on demand	_____
_____	_____ oz	every ____ hours	or	on demand	_____
_____	_____ oz	every ____ hours	or	on demand	_____

Cereal

Please date after introduction at home: _____ Rice _____ Oatmeal

<u>Date</u>	<u>Amount</u>		<u>Frequency</u>		<u>Initial</u>
_____	_____ T	Breakfast	Lunch	Dinner	_____
_____	_____ T	Breakfast	Lunch	Dinner	_____
_____	_____ T	Breakfast	Lunch	Dinner	_____

Baby Food-Fruit

Please date after introduction at home: _____ Applesauce _____ Bananas _____ Pears _____ Peaches

_____ Mango _____ Pineapple

<u>Date</u>	<u>Amount</u>		<u>Frequency</u>		<u>Initial</u>
_____	_____ T/jar	Breakfast	Lunch	Dinner	_____
_____	_____ T/jar	Breakfast	Lunch	Dinner	_____
_____	_____ T/jar	Breakfast	Lunch	Dinner	_____

Original Feeding Plan must be signed by physician. Updates to be made by parent/guardian.

Baby Food-Vegetables

Please date after introduction at home: _____ Carrots _____ Squash _____ Green Beans
 _____ Sw. Potatoes _____ Peas

<u>Date</u>	<u>Amount</u>	<u>Frequency</u>	<u>Initial</u>
_____	T/jar	Breakfast Lunch Dinner	_____
_____	T/jar	Breakfast Lunch Dinner	_____
_____	T/jar	Breakfast Lunch Dinner	_____

Table Food

Toddler Menu Food Choices

Please date as child transitions to table food: _____ soft foods in addition to baby food feedings
 _____ toddler menu supplemented with baby food as needed
 _____ toddler menu items only, no baby food
 _____ Chicken
 _____ Beef
 _____ Turkey

Milk

Please date after introduction at home: _____ whole milk
 _____ 2% milk w/ Dr. orders only

Special Instructions/Notes:

Known allergies: _____

Physician's notes: _____

Parent/guardian notes: _____

_____ Physician's Name	_____ Print	_____ Date
_____ Physician's signature		

Original Feeding Plan must be signed by physician. Updates to be made by parent/guardian.