

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:** _____