



Infant Feeding Plan

Child's Name: _____

Date: _____

Child's Date of Birth: _____

Does your child take a bottle? (yes)___ (no)___

Is the bottle warmed? (yes)___ (no)___

Does the child hold his/her own bottle? (yes)___ (no)___

Does your child take a pacifier? (yes)___ (no)___

Does the child eat:

Baby Food ()

Whole Milk ()

Table Food ()

Formula ()

Other () _____

What type of formula is used? _____

Amount of formula to be given? _____

Updated amounts on formula to be given _____ Date _____

_____ Date _____

_____ Date _____

Please list the foods that your baby does not like: _____

Please list all allergies: _____

Give us an idea I your child's schedule:

Breakfast: _____
(approximate time) (approximate amount)

_____ (approximate time) (approximate amount)

Lunch: _____
(approximate time) (approximate amount)

_____ (approximate time) (approximate amount)

Nap Times: _____

Introducing New Foods

Please Add _____ on _____
_____ on _____
_____ on _____
_____ on _____