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 _____
Does the child take a pacifier? Yes [ ] No [ ]
If yes, when? ____
Food likes _____
Dislikes _____
Allergies? (Include any premixed formula) _____

Formula/Breastmilk			**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 _____