Infant Feeding Plan

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

Does your child take a bottle? ☐ YES ☐ NO

Should we warm the bottle? ☐ YES ☐ NO

Does your child hold his/her own bottle? ☐ YES ☐ NO

Can your child feed him/herself? ☐ YES ☐ NO

Please check all that apply. Does your child eat/drink:

☐ formula if so, what type: _____

☐ strained foods ☐ junior foods

☐ whole milk ☐ table foods

☐ other
please note: _____

Does your child have any food allergies? ☐ YES ☐ NO Please list: _____
_____
_____

Is your child allergic to any commercial premixed formulas? ☐ YES ☐ NO Please list: _____
_____
_____

Child's Schedule

	Approximate Time	Type & Amount of food/formula
MORNING	_____	_____
	_____	_____
MID-DAY	_____	_____
	_____	_____
AFTERNOON	_____	_____
	_____	_____

Other feeding instructions : _____
Introduction of solid foods: _____

Parent Signature: _____ Date: _____

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