

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 []

CEDARS



PRESCHOOL
 — at —
Locust Grove

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:** _____