

Infant Feeding Plan

Date _____

Child's Name _____ Date of Birth _____

Does the child take a bottle? _____ Is the bottle warmed? _____
Does the child hold own bottle? _____
Can the child feed itself? _____
Does the child take a pacifier? _____
When? _____
Please list food that the child likes? _____
Please list food that the child dislikes? _____

Child's Current Foods Include:

Strained Foods	Yes or No	Baby Foods	Yes or No
Table Foods	Yes or No	Child Drinks	Yes or No
Whole Milk	Yes or No	Formula	Yes or No

If yes, please list type / amount of formula _____
Child is fed a bottle every _____ hours.

Child's Current Schedule:

Approximate Time

Type and Approximate Amounts

Breakfast _____

Lunch _____

Dinner _____

Does child take a nap in the morning? _____ If so how long? _____

Does child take a nap in the afternoon? _____ If so how long? _____

Parent's Signature _____ Date _____