Infant Feeding Plan

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

Does child take a bottle? ☐ Yes ☐ No
Is the bottle warmed? ☐ Yes ☐ No
Does the child hold their own bottle? ☐ Yes ☐ No
Can the child feed self? ☐ Yes ☐ No

Does the child eat: (Check all that apply)
☐ *Strained Foods* ☐ *Breast Milk* ☐ *Other (please list)*
☐ *Baby Foods* ☐ *Whole Milk*
☐ *Formula* ☐ *Table Foods*

What type of formula used? _____

Amount of formula/breast milk given? _____

Updated amounts of formula/breast milk:

Amount: _____ Date: _____
Amount: _____ Date: _____
Amount: _____ Date: _____
Amount: _____ Date: _____

Does the child take a pacifier? ☐ Yes ☐ No If yes, when: _____

Food Likes _____

Food Dislikes _____

Allergies (include any food/pre-mixed formulas) _____

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.
_____
_____
_____

Parent/Guardian Signature: _____ **Date:** _____