Infant Feeding Schedule

At Enrollment

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

What Does Your Child Drink?

__Breast Milk __Whole Milk

__Formula __Juice __Water

Does Your Child Like Their Bottle Warmed? __Yes __No

Does Your Child Drink out of a Sippy Cup? __Yes __No

How often does your child drink? _____How much? ____

Does Your Child Eat?

Jar Foods:

__Vegetables

__Fruits

__Meats or Mixed Dinners

__Fruits __Yogurt

Cereals:

__Rice

__Oatmeal

__Mixed Grain

Finger/Table Foods:

__ Cheerios, Puffs, etc.

__Soft Veggies & Fruits

Other: _____

_____

Child's Schedule:

Breakfast: Time: _____ Types and Amounts of Food/Bottle _____
_____

Lunch: Time: _____ Types and Amounts of Food/Bottle _____
_____

Snacks: Time: _____ Types and Amounts of Food/Bottle _____
_____

Does your child have a healthy appetite? _____
_____

Are there any known allergies that your child has? _____
_____

How often does your child take a nap? _____
_____**For long?** _____

Does your child take a pacifier? Yes___ No___ Sometimes___

Special Notes: _____
_____
_____

Parent's Signature: _____**Date:**_____

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