Building Blocks Learning Center

Infant Feeding Plan

Child's Name_____Date_____

Birthday_____

Does child take a bottle? Yes ( ) No ( )

Is the bottle warmed? Yes ( ) No ( )

Does the child hold own bottle? Yes ( ) No ( )

Can the child feed his/her self? Yes ( ) No ( )

Does the child eat? (check all that apply)

Strained Foods ( ) Whole milk ( )

Baby Foods ( ) Table Foods ( )

Formula ( ) Other_____

What type of formula is used?_____

What amount given?_____

Updated amounts of formula:_____Date:_____

_____Date:_____

_____Date:_____

_____Date:_____

Does the child take a pacifier? Yes ( ) No ( )

If yes, when?_____

Food likes?_____

Food dislikes?_____

Allergies? (Include any pre-mixed formula)_____

_____

Child's schedule: (Approximate Time) (Types and approximate amounts of food)

Breakfast _____ _____

Lunch _____ _____

Morning Snack _____ _____

Instructions for the introduction of solid food _____

_____

Any updated instructions regarding adding new foods or other dietary changes, please list as needed.

_____

_____

Parent's Signature_____Date_____