Infant Feeding Plan

Child's Name ______________________ Date of birth ______________

Does child take bottle? ☐ Yes ☐ No
Is the bottle warmed? ☐ Yes ☐ No
Does the child hold his/her own bottle? ☐ Yes ☐ No
Can the child feed self? ☐ Yes ☐ No

My child eats: (Check all that apply)

☐ Strained foods
☐ Baby foods
☐ Formula
☐ Breastmilk
☐ Whole Milk
☐ Table foods
☐ Other ______________

Type of formula used: ______________________

Amount of formula/breastmilk to be given: ______________________

Updated amount of formula/breastmilk:

Amount: ______________ Date updated: ______________
Amount: ______________ Date updated: ______________
Amount: ______________ Date updated: ______________

Does your child take a pacifier? ☐ Yes ☐ No If yes, when? ______________

Foods my child likes: ______________________

Foods my child dislikes: ______________________

Allergies? (Include any premixed formula) ______________________

FORMULA/BREASTMILK			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** ______________