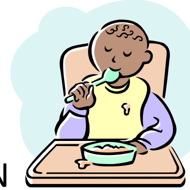
CORNERSTONE CHILDREN'S CENTER

INFANT FEEDING PLAN



Child's Full Name: ____ Date: __________

Date of birth: ________________________ Current Age: _______________

Does child take bottle? Yes [ ] No [ ]

Is the bottle warmed? Yes [ ] No [ ]

Does the child hold own bottle? Yes [ ] No [ ]

Can the child feed self? Yes [ ] No [ ]

Does the child eat: **(Check all that apply)**

[ ] Strained foods [ ] Whole milk

[ ] Baby foods [ ] Table foods [ ] Other

[ ] Formula [ ] Breast Milk

What type of formula is used? ____

Amount of formula/breast milk to be given: ____

Updated amounts of formula/breast milk: ________________________________ Date: ________

Amount: ____________________ Date: _______________________

Amount: ____________________ Date: _______________________

Amount: ____________________ Date: _______________________

Amount: ____________________ Date: _______________________

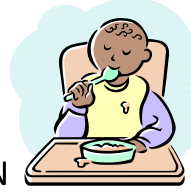
Does the child take a pacifier? Yes [ ] No [ ] If yes, when? ______________________________

Food likes: ____

Dislikes: ____

Allergies? (Include any premixed formula)____

INFANT FEEDING PLAN



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.

____

____

PARENTS' SIGNATURE: ____ Date: _______________