Infant Feeding Plan
(infants & toddlers)

**Please fill in all boxes/lines and update form as changes in feeding are made

Child's Name _____ Date _____

Birthday _____ Teacher _____

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

Does child eat: Strained Foods ( ) Whole Milk ( ) Formula ( )
Baby foods ( ) Table Food ( ) Other ( )

What type of formula is used? _____
Note: All bottles must be prepared at home. We can't mix powdered formula.
Amount of formula to be given _____
Updated amounts to be given _____ Date _____
_____ Date _____
_____ Date _____

Does child take a pacifier? _____ If so, When? _____

Food likes _____
Food dislikes _____

Allergies (including pre-mixed) _____
(Note: this line must be filled out)

Child's Schedule

Breakfast time_____ _____
type & approximate amount

Lunch time _____ _____
type & approximate amount

Dinner time _____ _____
type & approximate amount

Morning Nap time _____ Afternoon Nap time _____

Instructions for the introduction of solid foods _____
*** As needed, please update regarding adding new foods and dietary restrictions.

Parent/Guardian Signature _____