INFANT FEEDING SCHEDULE

To be updated at least monthly

Date of Completion: _____

1) Child's Name: _____ **2)** Date of Birth: _____

3) Does your child have any known food allergies?

[ ] **Yes** [ ] **No**

If Yes, please list the allergies and describe your child's reaction(s) if exposed:

_____

_____

_____

4) Please check any/all that are applicable:

[ ] **Formula** Name of Formula: _____

[ ] **Breast Milk**

Amount (ounces) of formula or breast milk in each bottle: _____ oz.

Updates to feeding amounts:

Date: _____ Amount: _____ oz. Parent Initials: _____

Date: _____ Amount: _____ oz. Parent Initials: _____

Date: _____ Amount: _____ oz. Parent Initials: _____

Date: _____ Amount: _____ oz. Parent Initials: _____

[ ] **Baby Cereal(s) and/or Semi-Solid Foods**: Please list the approved cereal(s) and/or semi-solid foods:

_____

_____

_____

_____

Updated list of approved baby cereal(s) and/or semi-solid foods:

Date: _____ Foods: _____ Parent Initials: _____

Date: _____ Foods: _____ Parent Initials: _____

Date: _____ Foods: _____ Parent Initials: _____

5) If your child is permitted to eat solid foods, please review the attached menu. Circle the approved foods and note the date approval was given. If your child is eating solid foods, he/she will follow the meal/snack schedule of the Center.

6) Parent(s)/Guardian(s) Suggested Feeding Schedule:

Approximate Time	Bottle/Food #1	Bottle/Food #2 (if applicable)

7) Comments:

_____

_____

_____

_____ _____

Parent/Guardian Signature **Date**