Infant Feeding Plan & Special Instructions

CHILD'S NAME: _____________________________________ DOB: ____________________

Parents,

Please update this form on the first of every month by making any necessary changes directly on this form, initialing next to changes made and then signing next to the current month.
Thank you!

Date Parent Initials

Jan. _____ ___________

Feb. _____ ___________

Mar. _____ ___________

Apr. _____ ___________

May _____ ___________

June _____ ___________

July _____ ___________

Aug. _____ ___________

Sept. ____ ___________

Oct. _____ ___________

Nov. _____ ___________

Dec. _____ ___________

BOTTLE FEEDINGS

Use: ___ Breast Milk ___ Formula, Type: ______________________

Feeding Schedule (include amount & how often or 'On Demand'):

_______ oz / every _______ hours or at specific times: _________

____

____

Should bottles be warmed? ___ Yes ___ No

How long can the bottle be left out? ___________________________

Can we re-warm the bottle? ___ Yes ___ No

Please explain: ____

SOLID FOODS (Please be specific & include snacks, juices, etc)

	Approx. Time	Food Item
Breakfast		
Lunch		
Snacks		
Other		

Are there any known food allergies? ___ Yes ___ No

If yes, please specify: ____

DIAPERING

Should wipes be used at each diaper change? ___ Yes ___ No

Which of the following may be used on your baby? (please circle)

Diaper Cream Powder Lotion Other _______________

SLEEPING SCHEDULE

What is your child's sleep schedule? Please list specifics below.

____

____

How do you get your child to sleep? (rocking, patting, etc.)

(Note: Babies have to sleep in pack-n-play unless doctor's note provided.)

____

What position do you prefer? (please circle) back side stomach

(Note: Infants have to be placed on back to sleep until they can roll.)

Does your child use a pacifier? ___ Yes ___ No

Please give a brief description of your child's temperament.

____

____

Does your child have any special needs?

____

____