

# Monthly- Infant Feeding Plan

Child's full name \_\_\_\_\_ Date \_\_\_\_\_

Date of birth \_\_\_\_\_

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 [ ]  
 Formula [ ] Other [ ]  
 Breast Milk [ ]

What type of formula used? \_\_\_\_\_

Amount of formula/breast milk to be given? \_\_\_\_\_

Updated amounts of formula/breast milk: \_\_\_\_\_ 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) \_\_\_\_\_

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. \_\_\_\_\_

**Parent's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Parent's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Parent's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## Diapering Procedure

**Instructions:** (Please write your preferred diapering procedure for staff to follow)

### Nap Time:

Time: \_\_\_\_\_ Length: \_\_\_\_\_  
Time: \_\_\_\_\_ Length: \_\_\_\_\_  
Time: \_\_\_\_\_ Length: \_\_\_\_\_  
Time: \_\_\_\_\_ Length: \_\_\_\_\_