Champions for Children
Infant Feeding Plan

Child's Name_________________________________ Date ______________________________
Child's Birthday ______________________________

Does the child take a 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:

Strained foods	( )	Whole Milk	( )
Baby foods	( )	Table foods	( )
Formula	( )	Other	( )

If other, please list: ____
What type of formula is used? ____
Amount of formula to be given? ____
Updated amounts of formula?____________________________ Date ____________________
____________________________ Date____________________
____________________________ Date____________________

Does the child take a pacifier? Yes ( ) No ( ) If yes, when?___________________
Food likes ______________________________ Food dislikes______________________________

Allergies (which includes any premised formula)?_______________________________________

Child's Schedule
Breakfast _______________________ ______________________________________
Approximate Time Types and approximate amounts of food
Lunch__________________________ ______________________________________
Approximate Time Types and approximate amounts of food
Dinner__________________________ ______________________________________
Approximate Time Types and approximate amounts of food

Instructions for the introductions of solid foods _______________________________________
____

Any updated instructions regarding adding new foods or other dietary changes please list as needed ____
____

Parent/Guardian Signature___________________________