INFANT FEEDING AND CARE PLAN

CHILD'S NAME____**DATE**____________________

BIRTHDATE____**AGE**______________________

Does your child take a bottle? **Yes**_______ **No**______
Is the bottle warmed? **Yes**_______ **No**______
Does the child hold the bottle? **Yes**_______ **No**______

Does your child eat: (Check and indicate amount)

Strained Foods	**Yes**______	**No**______	______________________________
Table Food	**Yes**______	**No**______	______________________________
Formula	**Yes**______	**No**______	______________________________
Whole Milk	**Yes**______	**No**______	______________________________
Other	**Yes**______	**No**______	______________________________

Food Likes____
Food Dislikes____
Allergies____
List name of formula used____
Do you want your child's leftover formula used or discarded? ___________________________
List any formulas NOT to be used in an emergency_________________________________

CHILD'S BREAKFAST____
(approx. time) **(type and approx. amount of food)**

LUNCH____
(approx. time) **(type and approx. amount of food)**

BOTTLES____
(approx. time) **(type and approx. amount of food)**

NAP INSTRUCTIONS
Does your child use a pacifier? **Yes**___ **No**___
When?____
Time of morning nap____
Time of afternoon nap____

Do you use powder when changing your child. Yes____ No____
Do you use any creams or gels when changing your child? Yes____ No____
If yes, please list____
Please bring any items listed about to be kept in your child's basket.

Comments: ____
____
____

Parent's signature____

NOTE! IT IS THE PARENT'S RESPONSIBILITY TO UP-DATE THIS FORM EACH TIME CHANGES TAKE PLACE. PLEASE DO NOT LEAVE ANY LINES BLANK.