East Cobb Prep
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:
Amount: ____ 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.

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PARENTS' SIGNATURE: ____________________________________ Date: ___________________