INFANT FEEDING PLAN

Child's Name: _____ Birth date: _____

Date of Evaluation: _____ Age at Evaluation: _____

ALLERGIES

Does your child have any allergies? ☐ No ☐ Yes: _____

MILK

What type of milk does your child drink? ☐ Breast Milk ☐ Milk, type: _____

☐ Formula, Brand: _____ ☐ None

How much per feeding? _____ How many times per day? _____

CEREALS

Please list the types of cereals your child eats: _____

_____

How much per feeding? _____ How many times per day? _____

FRUITS AND VEGETABLES

Please list the types of fruits and vegetables your child eats: _____

_____

How much per feeding? _____ How many times per day? _____

JUICES OR WATER

Please check what your child uses to drink: ☐ Cup ☐ Bottle ☐ Sippy Cup

Please check what your child drinks: ☐ Water ☐ Juice, Flavors: _____

How much per feeding? _____ How many times per day? _____

FINGER FOODS

Please list the types of finger foods your child eats: _____

_____

How much per feeding? _____ How many times per day? _____

OTHER

Please list the other types of foods (e.g. meat, fish, eggs, beans) that your child eats: _____

_____

How much per feeding? _____ How many times per day? _____

Can your child feed himself/herself? ☐ Yes ☐ No

_____ _____

Parent's Signature Caregiver's Signature

Parent Updates (Initial and Date): _____ _____ _____

Teacher Updates (Initial and Date): _____ _____ _____