

Infant Monthly Feeding Schedule

Child's Name: _____ Date: _____

How often does your child take a bottle (Approximately in hours) _____

Do we need to wake to feed? _____ Yes _____ No

If so, at what point do we wake (ex: after 3hours since last feeding, etc) _____

Do we need to wake for a diaper? _____ Yes _____ No

When do we need to apply your child's diaper cream?

_____ Every Change _____ As Needed _____ No Diaper Cream Needed

What does Your child drink?

_____ Breastmilk _____ Whole Milk

_____ Formula _____ Juice

_____ Water

Does your child drink out of a sippy cup?

_____ Yes _____ No

How does your child like his/her milk?

_____ Very Warm _____ Warm _____ Room Temp _____ Cold

What does your child eat?

Purees

_____ Yellow Veg

_____ Orange Veg

_____ Green Veg

_____ Meats or Mixed Dinners

Cereals

_____ Rice

_____ Oatmeal

_____ Mixed Grain

Finger/Table Foods

_____ Cheerios/Puffs/Melts

_____ Soft Veg/Fruits

_____ Class Menu

Does your child have a healthy appetite: _____

Do you have any concerns about your child's eating? _____

Does your child have any allergies: _____

Does your child take a pacifier: _____ Yes _____ No _____ Sometimes

How often does your child nap? _____

What is the best way to help your child sleep? _____

Child Schedule:

Bottles every _____ Hours

Breakfast: _____ (time) _____ (type of Food)

Lunch: _____ (time) _____ (type of Food)

Dinner: _____ (time) _____ (type of Food)

Special

Notes: _____

Parent Signature: _____ Date: _____