Infant Feeding and Care Plan

In an attempt to smoothly facilitate your child's transition, please fill out the following form.
This information is confidential.

Child's Name _____ Date _____ Birth date_____

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 Food	[ ]
Formula	[ ]	Other	[ ]

What type formula used? _____
Amount of formula to be given? _____
Updated amounts of formula? _____ Date _____
_____ Date _____
_____ Date _____
Does the child take a pacifier? Yes [ ] No [ ]
When? _____
Food likes _____ Food dislike_____
Allergies- including any premixed formula _____

Child's Schedule

Breakfast _____ _____
Approximate Time Types and approximate amount of food

Lunch _____ _____
Approximate Time Types and approximate amount of food

Dinner _____ _____
Approximate Time Types and approximate amount of food

Morning Nap _____ Afternoon Nap _____
Approximate Time Approximate Time

Instructions for the introduction of solid foods _____

_____
As needed, please list updated instructions regarding adding new foods or other dietary changes.

_____

Has your child had any feeding problems? (Please describe in detail)

_____

Is your child: ☐ breast fed ☐ bottle fed ☐ weaned

Supplemental infant information:

Describe your child's present napping pattern _____

_____

Does your child usually cry when going to sleep? ☐ No ☐ Yes
Does your child cry when waking? ☐ No ☐ Yes
Do you have any special ways of helping your child go to sleep?_____

_____

Does your child have any special needs?_____

_____

_____

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

Has your child had a serious illness? ☐ No ☐ Yes Describe: _____

_____

Has your child had any surgical procedures? ☐ No ☐ Yes Describe: _____

_____

Does your child take any medications on a regular basis? (Please give details)_____

_____

_____

Please indicate which of the following diseases your child has previously experienced:

☐ Whooping Cough	☐ Pneumonia	☐ Mumps
☐ Chicken Pox	☐ Measles (10 day)	☐ Allergies
☐ Eczema	☐ High Temperature (Over 103)	☐ Neurological
☐ Roseola (24 Hr. Measles)	☐ Rubella (3 day-German measles)	☐ Recurrent Ear Infections

☐ Other _____

Please take a moment to tell us any thing else that would help us to provide the best care for your child.

_____

_____

_____

_____

_____

_____

_____

Parent/Guardian Signature _____ Date _____