Infant Feeding Schedule

Child's Name_____ D.O.B_____

Check appropriate age range: Birth-3 mon.___ 4-7 mon.___ 8-11 mon.___ 12 Mon. + ____

P.S. 1304.23 (c) (5) Infants are held while being fed and are not laid down to sleep with a bottle. All infants **must sleep facing up.**

Napping Schedule: _____

Times bottles normally given:

A.M.	P.M.
1.	1.
2.	2.
3.	3.
4.	4.

Breastfed: Yes_____ No_____ Formula:_____ Ounces: _____

Temperature of formula: Luke-Warm_____ Room-Temperature _____

P.S. 1304.23 (3)(1): A variety of foods is served which broadens each child's food experience

List all parent approved baby foods:

Cereal	Fruits	Vegetables	Meat

Pacifier: Yes_____ No _____

Comments/Specific Needs: (example: pacifier, burp half way through bottes, likes to be rocked, etc.)

_____

_____

_____

Food Allergies: _____

Special Diet: _____

Parent Signature: _____ Date: _____

Staff Signature: _____ Date: _____

NOTE: Feeding schedule will be signed and dated monthly with any revisions necessary