

Infant Feeding Schedule

Month of

Child's Name _____

Date of Birth _____

Today's Date _____

Instructions

1. Table Food: Yes or No _____
2. Breast Fed, Formula Fed, or Whole Milk _____
(If on table food and whole milk, you may jump down to number 15)
3. How Many ounces: _____
4. Room Temperature or Warmed: _____
5. How Often: _____
6. Taken in a bottle or sippy: _____
7. May we feed early? _____
8. If we feed early, how early can we feed _____
9. Do you want us to wake your child to feed if they are asleep _____
10. If no, how long after the bottle is due do you want us to wait: _____
11. Baby Food: Yes or No _____
12. If yes, please indicate flavors or write "any"

13. If yes to baby food, we usually give baby food at 8 am and 11 am. Do you have a preference to when you're your baby is fed baby food?

14. Rice cereal or oatmeal: Yes or No _____
15. Does your child take a pacifier? Yes or No _____
16. Do you want to know if they reach milestones in class? (i.e. crawling, walking, talking, sitting)

17. Anything else you would like us to know for the next month?

Parent Signature: _____ Date: _____

(The feeding schedule must be returned to the child's class before the end of the month for the next month, please)