Lascassas Baptist Preschool
Infant Feeding Plan

This Infant Feeding Plan was created for: ____
child's full name

Date Starting: _______________ ***Child's Age:*** _______________

What does your child primarily drink?

Do you provide any other supplemental liquids? If so, what?

Please describe your child's usual pattern of eating – include details such as how much and how often.

Complete the table below.

Daily Feeding Schedule:

	FOOD TYPE	AMOUNT
Ex.	*(Breast Milk/Formula/Jar/Puffs, etc)*	[5 oz.]
7:00		
8:00		
9:00		
10:00		
11:00		
12:00		
1:00		
2:00		
3:00		
4:00		
5:00		

Additional Directions:

____

____

____

____

____

Please be specific in your directions so we know how best to feed your child. More info is better than not enough. ☺

If your child is drinking breast milk, what do you wish the center to do if we run out of breast milk?

At this time, does your child consume any type of solid food? If so describe what and when?

Does your child have any food allergies or sensitivities that you are aware of?

Does your child have any difficulties with feeding such as spitting up or choking?

Please provide below any additional information we should know about your child's eating habits:

This Infant Feeding Plan was created by:

Parent/Guardian:

Name	Signature	Date

Staff Member:

Name	Signature	Date

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Additional Notes

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