

## Mountain View Prep Infant Feeding Plan

Child's Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Birthday: \_\_\_\_\_

Does child take a bottle?  Yes  No      Is the bottle labeled?  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: (check all that apply)  
 Strained foods  Formula  Baby foods  Whole Milk  Table foods  
 Other: \_\_\_\_\_

What type of formula is used? \_\_\_\_\_

**\*\*Center cannot mix powdered baby formula**

Amount of formula to be given: \_\_\_\_\_

Updated amounts of formula: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_

Instructions for the introduction of solid foods: \_\_\_\_\_

Food Likes \_\_\_\_\_

Food Dislikes \_\_\_\_\_

Does child take a pacifier?  Yes  No

When? \_\_\_\_\_

Allergies: (Include any premixed formula)  Yes  No

If yes, please list: \_\_\_\_\_

\_\_\_\_\_

### CHILD'S SCHEDULE

Breakfast: \_\_\_\_\_ (Approximate time)      \_\_\_\_\_ (Type and approximate amount of food)

Lunch: \_\_\_\_\_ (Approximate time)      \_\_\_\_\_ (Type and approximate amount of food)

Dinner: \_\_\_\_\_ (Approximate time)      \_\_\_\_\_ (Type and approximate amount of food)

Morning Nap: \_\_\_\_\_ (Approximate time)      Afternoon Nap: \_\_\_\_\_ (Approximate time)

Updated instructions regarding adding new foods or other dietary changes. Please list as needed:

Changes, N/A if none	Date	Parent Signature

\_\_\_\_\_  
 PARENT SIGNATURE

\_\_\_\_\_  
 DATE