Monthly Dietary Information

Today's Date		
Child's Name	Date of Birth mm/dd/yyyy	Child's Current Weight lbs oz
Is your child on formula? Yes or No or Milk Yes or No		
My child currently drinks:_____ounces of _____formula/milk every_____hours		
Is your child on baby food? Yes or No		
List the varieties you use (fruits, veggies, meats, cereals, etc):		
Breakfast consist of:		
Lunch consist of:		
Snack consist of:		
ALLERGIES: List all food allergies or write none known		

Getting to know your infant

Does your baby sleep well on his/her back? Yes or No *Per State licensing no items may be placed into cribs with infants (children under 12 month and younger) including but not limited to stuffed animals, blankets, quilts, pillows, comforters or bumpers pads. Basically the only thing that can be in the crib is the baby and a sleep sack.
Does your child use a pacifier? Yes or No
Does your child's bottle require a bottle warmer? Yes or No
Check the milestones that your child has reached: ☐ Holding his/her head up ☐ Turning over ☐ Sitting up ☐ Walking ☐ Crawling ☐ Holding own bottle ☐ Drinking from a sippy cup
Please list any other important information or special instructions on the care of your child below:
Parent Signature: Today's Date: