Infant Monthly Feeding Schedule

Child's Name:_____ Date: _____

How often does your child take a bottle (Approximately in hours) _____

Do we need to wake to feed? _____ Yes _____ No

If so, at what point do we wake (ex: after 3hours since last feeding, etc) _____

Do we need to wake for a diaper? _____ Yes _____ No

When do we need to apply your child's diaper dream?

_____ Every Change _____ As Needed _____ No Diaper Cream Needed

What does Your child drink?

_____Breastmilk _____Whole Milk

_____Formula _____Juice

_____Water

Does your child drink out of a sippy cup?

_____Yes _____No

How does your child like his/her milk?

_____Very Warm _____Warm _____Room Temp _____Cold

What does your child eat?

Purees	Cereals	Finger/Table Foods
____Yellow Veg	_____Rice	____Cheerios/Puffs/Melts
____Orange Veg	_____Oatmeal	____Soft Veg/Fruits
____Green Veg	_____Mixed Grain	____Class Menu
____Meats or Mixed Dinners		

Does your child have a healthy appetite: _____

Do you have any concerns about your child's eating? _____

_____

Does your child have any allergies: _____

_____

Does your child take a pacifier: _____Yes _____No _____Sometimes

How often does your child nap? _____

What is the best way to help your child sleep? _____

Child Schedule:

Bottles every _____ Hours

Breakfast: _____ (time) _____ (type of Food)

Lunch: _____ (time) _____ (type of Food)

Dinner: _____ (time) _____ (type of Food)

Special Notes:_____

_____

_____

____

Parent Signature: _____ Date: _____