INFANT FEEDING SCHEDULE

____________________ Child's Name

____________________ Birth Date

Formula **or** **Milk**

How Much? ____________________

How Often? ____________________

Powder or Liquid: ____________________

Mixing Instructions: ____________________

____

Baby Foods		**How Much?**	**How Often?**
Cereal			
Meat			
Fruit			
Veg.			
Other			

Table Foods		**How Much?**	**How Often?**
Cereal			
Meat			
Fruit			
Veg			
Other			

Any Additional Instructions: ____________________

____

List any foods that you DO NOT want your child to have: ____________________

____

I understand that the center does not sterilize the bottles after use but will follow the directions above to prepare my child's foods.

____________________ Parent's Signature — ____/____/____ Date

____________________ Administrator's Signature — ____/____/____ Date

____________________ Teacher's Signature — ____/____/____ Date