INFANT FEEDING FORM

CHILD'S NAME: _____DATE OF BIRTH: _____

MOTHER'S NAME: _____FATHER'S NAME: _____

- ***FEEDING:***

DOES YOUR CHILD TAKE THE BOTTLE? YES _____ NO _____
HOW DOES HE/SHE TAKE THE BOTTLE? WARM? _____ COLD _____
HOW OFTEN? _____
WHAT TYPES OF MILK DOES YOUR BABY DRINK?
FORMULA ____ SOY MILK ____
BREAST MILK ____ WHOLE MILK ____

NOTE: ALL BOTTLES ARE WARMED IN THE SLOW COOKER AND NOT THE MICROWAVE

DOES YOUR CHILD EAT BABY JAR FOODS? YES _____ NO _____
WHAT TYPES? FRUITS _____VEGETABLES _____MEATS _____
DOES YOUR BABY EAT SOLID FOODS? YES _____ NO _____

BE SURE TO PICK UP A COPY OF THE LUNCH MENU IN THE FRONT OFFICE THE FIRST OF THE MONTH

WHAT DOES YOUR BABY LIKE TO EAT? _____

PLEASE NOTE THAT TEETHING BUSCITS ARE NOT ALLOWED IN THE CENTER DUE TO THE RISK OF CHOKING

- ***SLEEPING***

HOW MANY A.M. NAPS DOES YOUR BABY TAKE? _____HOW LONG? _____
HOW MANY P.M. NAPS DOES YOUR BABY TAKE? _____ HOW LONG? _____
DOES YOUR BABY USUALLY HAVE A NA ROUTINE? YES _____ NO _____
WHAT IS THE NAP ROUTINE? _____

OUR CENTER USUALLY PROMOTES SLEEPING ON THEIR BACKS UNTIL THE CHILD IS MOBILE AND ABLE TO ROLL OVER ON THEIR OWN.

- ***HEALTH:*** DOES YOUR BABY HAVE ANY HEALTH PROBLEMS THAT ARE CONTINUOUS? (PLEASE LIST) _____

IS THERE ANY OTHER INORMATION ABOUT YOUR BABY THAT YOU WOULD LIKE TO SHARE? (PLEASE LIST) _____

_____/____
Parent or physician Signed/Date