

MILLER CHILD DEVELOPMENT CENTER

INFANT FEEDING INSTRUCTIONS

Child Name: _____ Date of Birth: _____

Allergies: _____ Medical Problems: _____

Special Care Needs: _____

Brand of Formula: _____ Bottles Per Day: _____

2% or Whole Milk: _____ Bottle or Cup: _____

Baby Food: _____ Fruit: _____ Vegetables: _____

Does your child eat table food? : _____ Yes _____ No

If yes, what kind: _____

Breakfast

Lunch

Snack

Bottles

_____ Oz. Time: _____ am / pm

Parent Signature: _____ Date: _____

Parent Signature: _____ Date: _____

Parent Signature: _____ Date: _____

NOTE: MUST BE REVIEWED, SIGNED, AND UPDATED BY PARENTS EVERY 30 DAYS UNTIL BABY IS READY FOR TABLE FOOD.