

Heritage Infant Feeding Schedule

Child's information:

Child's name: _____ DOB: _____

Parent's name: _____ Date: _____

Feeding Plan:

Liquids-

Child is to be fed the following:

- Breast Milk
- Formula- Brand _____
- Milk- Special _____
- Juice

Child now uses:

- Bottle
- Cup
- Spoon
- Fork

What age do you plan to introduce your child to:

Bottle _____
Cup _____
Spoon _____
Fork _____

Solid Foods-

Child is currently on solid foods? Yes No

Child can feed self? Yes No

What age (if not currently) did you begin to introduce solid foods? _____

Feeding Schedule-

How many ounces or cups per day? _____

Breast Milk _____ Formula _____ Milk _____ Juices _____

Approximately what time do you usually offer your child solid foods? _____

What time of day do you want us to offer solid foods? _____

Foods child likes: _____

Foods child dislikes: _____

Food Allergies:

Allergy special instructions:

Sleeping Patterns:

Sleeping Schedule-

Does your child take a nap in the morning? Yes No

Approximately what time? _____ Usually how long? _____

Does your child take a nap in the afternoon? Yes No

Approximately what time? _____ Usually how long? _____

Does your child sleep with any transitional objects (blankets, pacifier, etc.)? Yes No

If yes, what objects? _____

Special instructions: _____

Diapering and Toilet Training Plan:

Diaper/Toilet Training-

Infants and toddlers will be checked frequently and will be kept clean and dry. Child uses:

Disposable diapers- Brand _____

Wipes- Brand _____

Training Pants- Brand _____

Potty chair

Toilet

Any other products which may be used on your child: _____

Special Instructions: _____

Method of toilet training : _____

At what age would you like to start the introduction and use appropriate:

Training equipment: _____

Training pants: _____

Notes:

Schedule for Solid and New Foods:

Food Groups	Age	Specific Food	Consistency
Bread & Cereals			<input type="checkbox"/> Strained <input type="checkbox"/> Chopped <input type="checkbox"/> Whole
Fruits			<input type="checkbox"/> Strained <input type="checkbox"/> Chopped <input type="checkbox"/> Whole
Vegetables			<input type="checkbox"/> Strained <input type="checkbox"/> Chopped <input type="checkbox"/> Whole
Meats			<input type="checkbox"/> Strained <input type="checkbox"/> Chopped <input type="checkbox"/> Whole
Dairy Products			<input type="checkbox"/> Strained <input type="checkbox"/> Chopped <input type="checkbox"/> Whole

Special instructions from child's pediatrician relating to diet:

Individual Infant and Toddler Activities:

An individual monthly plan covering all areas of development will be designed at the beginning of each month and reviewed with the parent. A copy of the plan, approved by staff and parent will be kept in the child's file and in the classroom.

Individual Schedule of the Infant/Toddler Routine:

Arrival Time: _____ Pick up Time: _____
Morning Feedings: _____ Morning Nap: _____
Mid day Feedings: _____ Mid day Nap: _____
Evening Feedings: _____

Active play, diapering and toileting and all other interactions will be provided around your child's routine.

This form is required to be updated four times per year as your child's needs change and reviewed with parent/guardian prior to being signed and approved by persons listed below.

Parent/Guardian's Signature Date

Teacher's Signature Date

Center Director's Signature Date