Infant Daily Eating Schedule

Child's Name_____ **Date of Birth**_____

Bottles

_____ounces @_____ _____ounces @_____

_____ounces @_____ _____ounces @_____

_____ounces @_____ _____ounces @_____

Solids

_____ @_____ _____ @_____

_____ @_____ _____ @_____

Does your baby have any known food allergies? Yes No
If yes, please explain:_____

Does your baby eat: Baby cereal Baby food Soft table food
Comments:_____

Does your baby drink: Formula Breast milk Juice 1% Milk Whole Milk Water
Comments:_____

Does your baby drink from a sippy cup? Yes No

Does your baby prefer his/her bottles: Warm Room Temperature
Comments:_____

Does your baby hold his/her own bottles? Yes No

Does your baby use a pacifier? Yes No

Comments

_____
_____
_____
_____

Parent's Signature_____ **Date**_____