Crème *de la* Crème®
CHILD CARE • PRESCHOOL • AFTER SCHOOL
Early Learning Centers Of Excellence®

Infant Feeding Plan
Transition to Table Food

Child's Name: _____ Birthday: _____ Date: _____

Does the child take formula/whole milk? Yes [ ] No [ ]
Does the child take a bottle? Yes [ ] No [ ]
Is the bottle warmed? Yes [ ] No [ ]
Does the child hold own bottle? Yes [ ] No [ ]
Can the child feed self? Yes [ ] No [ ]

Amount of formula/whole milk to be given? _____
Updated amounts of formula/whole milk: _____ Date: _____
_____ Date: _____
_____ Date: _____

Table food additions: _____ Date: _____ Signature: _____
_____ Date: _____ Signature: _____
_____ Date: _____ Signature: _____

Does the child eat:

Strained Foods [ ]	Whole Milk [ ]
Baby Foods [ ]	Table Food [ ]
Formula [ ]	Other [ ]

Does the child take a pacifier? Yes [ ] No [ ]
When? _____

Food likes: _____ Food dislike: _____
Allergies- including any premixed formula: _____

Child's Schedule (please list approximate times, approximate types and approximate amounts of food)

Breakfast: _____

Lunch: _____

Dinner: _____

Morning Nap: _____

Instructions for the introduction of solid foods: _____

As needed, please list updated instructions regarding adding new foods or other dietary changes.

_____

Parent/Guardian Signature: _____