Revised 9/10

DEPARTMENT OF
PUBLIC HEALTH AND HUMAN SERVICES

STATE OF MONTANA

INFANT FEEDING SCHEDULE

Infant/Child's Name: _____ Date of Birth: _____

Parent's Name: _____

An individual form must be completed for all infants, ages 0 to 24 months.

Note the type of breast milk, infant formula, milk, and other foods that the infant normally uses and the average daily amount they consume. **This needs to be updated any time food is added to an infant's diet.**

	Type	Average Daily Amount
Breast Milk:		
Infant Formula:		
Milk:		
Other Foods:		

List the approximate times that the infant eats, what the infant normally eats at each designated time, and the approximate amount (i.e. ounces):

Time:	Breast Milk, Infant Formula, Milk, and Other Foods

List any special considerations, (i.e. food allergies):

_____

_____

_____

_____

_____ _____

Parent Signature Date Provider Signature Date