INFANT CARE/FEEDING INSTRUCTION SHEET

(FOR USE UNTIL AN INFANT IS EATING TABLE FOOD)

CHILDS NAME_____DATE OF BIRTH_____

NAME OF FORMULA AND TYPE_____WARMED?_____

DOES YOUR CHILD DRINK JUICE?_____

ANY SERVING INSTRUCTIONS_____

TYPE OF BABY FOODS CONSUMED: CEREAL?_____

MEATS_____VEGGIES_____FRUIT?_____

WHEN AND HOW MUCH?_____

ANY ALLERGIES? IF YES PLEASE DESCRIBE SYMPTOMS TO WATCH FOR:

_____

DO WE HAVE PERMISSION TO USE: BABY POWDER? _____BRAND:_____

DIAPER RASH OINTMENT? _____BRAND:_____

LOTION? _____ BRAND: _____

YOU CHILD WILL BE PLACED ON HIS/HER BACK TO SLEEP UNLESS WE RECEIVE A NOTE FROM YOUR PHYSICIAN STATING THAT IT WOULD BE BEST FOR HIM/HER TO SLEEP ON HIS/HER STOMACH.

DOES YOUR BABY USE A PACIFIER? _____

ANY OTHER HELPFUL INFORMATION? _____

_____

PLEASE NOTE THAT THIS FORM NEEDS TO BE UPDATED EVERY 30 DAYS UNTIL THE CHILD IS EATING TABLE FOOD AND ON WHOLE MILK.

PARENT SIGNATURE: _____ DATE: _____

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