INFANT DIETARY PLAN

Child's Name: _____
Today's Date: _____ Date of Birth: _____

Does your infant have any special dietary restrictions / sensitivities? ☐ Yes ☐ No
If so, what are they?

_____

_____

*Family to provide special food/drink if needed (i.e. Almond Milk, Soy Butter, etc)

Does your infant have any allergies? ☐ Yes ☐ No
If so, please provide the following two forms:
☐ Healthcare Provider Documentation Plan
☐ DHS Individual Child Care Program Plan

Bottle Frequency: _____ Ounces every _____ Hours - OR - ☐ On Demand

Bottle Type: ☐ Breastmilk ☐ Formula ☐ Whole Milk ☐ Other: _____

Does your infant like his / her bottle: ☐ Warm ☐ Room Temperature ☐ Cold

Does your infant use a sippy cup? ☐ Yes ☐ No With? ☐ Water ☐ Milk ☐ Formula ☐ Breastmilk

Does your child eat any purees or infant cereal? ☐ Yes ☐ No
If so, what? _____

Puree Frequency (select all applicable): ☐ Breakfast ☐ Lunch ☐ Snack Amount: _____

Cereal Frequency (select all applicable): ☐ Breakfast ☐ Lunch ☐ Snack Amount: _____

List any table / solid food New Creations is allowed to give based on our menu:

_____

_____

Table / Solid Frequency (select all applicable): ☐ Breakfast ☐ Lunch ☐ Snack

Will you be bringing in any foods from home you'd like us to use? ☐ Yes ☐ No
If so, what? _____

***Each time there is a change in your infant's feeding schedule, or when a child moves up to a new classroom, his / her teacher will need the change in writing. A new dietary form can be picked up from the classroom.**

_____ _____
Parent / Guardian Signature: Date