Infant Schedule Summary

Today's Date: _______________

Child's Name: ______________________________________ **Date of Birth**: ______________________

Diaper Cream: yes or no **Brand**: __________________ **Frequency**: _______________________

Feedings

Does your child have any food allergies? yes or no
(Reminder: All new foods must be tried at home first)

If yes, please list the allergies and describe your child's reaction if exposed:

____

____

My child drinks/eats approximately every ______ hours.

Please check any/all that are applicable:

____Breast Milk ____Formula: Name of Formula: ____________________

____Baby Cereal(s) and/or Semi-Solid Foods: Please list the cereal(s) and/or semi-solid foods that have already been tried at home and are approved for your infant to have:

____

____

____

____

Amount (ounces) per bottle of formula or breast milk: _________oz

Are bottles heated for your child? yes or no

Updates to feeding amounts:

Date: _______________ Amount: _______________oz Parent Initials: _______________

Date: _______________ Amount: _______________oz Parent Initials: _______________

Date: _______________ Amount: _______________oz Parent Initials: _______________

Date: _______________ Amount: _______________oz Parent Initials: _______________

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Updates list of approved baby cereal(s) and/or semi-solid foods:

Date: ___________ Foods: ________________________________ Parent Initials: _______________

Date: ___________ Foods: ________________________________ Parent Initials: _______________

Date: ___________ Foods: ________________________________ Parent Initials: _______________

Date: ___________ Foods: ________________________________ Parent Initials: _______________

Parent(s)/Guardian(s) Suggested Feeding Schedule:

Approximate Time	Bottle or Food #1	Bottle or Food #2

Comments: ____

Approximate Sleeping Times

Morning: ________________

Afternoon: ________________

Evening: ________________

OR

☐ As needed. No set sleep schedule.

Parent Information

Parent Name: ______________________ Daytime Phone: _____________________

Cell Phone #: ______________________

Parent Name: ______________________ Daytime Phone: _____________________

Cell Phone #: ______________________

Who should be contacted first in the event of illness? ______________________________

Is it appropriate to telephone you at work, even in non-emergency situations? _____________

Parent Signature: _________________________ Date: ____________________________

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