Kids are Angels Learning Center

Nursery/Infant Feeding Schedule

NAME: _____ DATE: _____

DATE OF BIRTH: _____

ALLERGIES: _____

MEDICAL PROBLEMS: _____

EMERGENCY PHONE NUMBER(S): _____

BRAND OF FORMULA: _____ BOTTLES PER DAY: _____

1% MILK: _____ BOTTLE OR CUP: _____

BABY FOOD: _____ FRUIT: _____ VEGETABLES: _____

DOES YOUR CHILD EAT TABLE FOOD? _____ WHAT KIND? _____

_____

BREAKFAST: _____ TIME: _____

MORNING BOTTLE: _____ TIME: _____

LUNCH: _____ TIME: _____

AFTERNOON BOTTLE: _____ TIME: _____

AFTERNOON SNACK: _____ TIME: _____

OTHER: _____

TYPE OF DISPOSABLE DIAPERS: _____

PLEASE LABEL ALL FOODS AND BOTTLES

PARENTS: PLEASE LET US KNOW WHEN YOUR BABY'S DIET CHANGES (I.E. CHANGING TO A DIFFERENT FOOD OR FORMULA OR GOING TO TABLE FOOD). THIS FORM MUST BE UPDATED, SIGNED AND DATED EVERY 30 DAYS.

_____ _____

PARENT SIGNATURE DATE