INFANT SCHEDULE

Child's Name_____

DOB_____ Date_____

Parents Name_____Parent's Signature_____

Liquids

Breast Milk - Formula - Milk - Juice-Water Bottle - Sippy Cup

Kind of liquid	Approx. Time or how often	How many Ounces

Meals-Snacks

Type of food	Approx. Time or how often	How much

Cereal preparation

Please explain how much cereal we will add to how much liquid (water,formula,breast milk)

Please provide measuring device._____

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Special Instructions: Napping,Diaper changes or any other important information:

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