



DEPARTMENT OF  
PUBLIC HEALTH AND HUMAN SERVICES

STATE OF MONTANA

INFANT FEEDING SCHEDULE  
SAMPLE

Infant/Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent's Name: \_\_\_\_\_

**An individual form must be completed for all infants, ages 0 to 24 months.**

Note the type of formula, milk, juice, and/or solids that the infant normally uses and the average daily amount they consume. **This needs to be updated any time food is added to an infant's diet.**

	Type	Average Daily Amount
Formula:		
Milk:		
Juice:		
Solids:		

List the approximate times that the infant eats and what he normally eats at each designated time. Formula; Milk; Juice; Solids and the approximate amount (i.e. ounces):

Time:	Formula, Milk, Juices, Solids

List any special considerations, (i.e. food allergies):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Provider Signature

\_\_\_\_\_  
Date