**Infant Feeding Schedule**

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| --- | --- |
| **Date:** Click or tap to enter a date. |  |
| **Child’s Name**: Click or tap here to enter text. | **Birth Date**: Click or tap to enter a date. |
| **Name of Provider**: Click or tap here to enter text. |  |

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| The Child Care and Early Years Act requires that all children under 12 months of age have a written Feeding Schedule.  Please give the schedule to your provider and update regularly as you and your doctor decide to add new foods. |

**(To be complete in by Parent)**

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| --- | --- | --- | --- |
| **What Kind** | **Amount** | **Time** | **Observation/Comments** |
| **Morning** |  |  |  |
| **First Snack** |  |  |  |
| **Lunch** |  |  |  |
| **Second Snack** |  |  |  |
| **Other** |  |  |  |



Date: Click or tap to enter a date.