Infant Feeding Plan

As your child's caregivers, an important part of our job is feeding your baby. The information you provide below will help us to do our very best to help your baby grow and thrive. **Page two of this form must be completed and posted for quick reference for all children under 15 months of age.**

Child's name: _____ Birthday: _____
m m / d d / y y y y

Parent/Guardian's name(s): _____

Did you receive a copy of our "Infant Feeding Guide?" Yes No

If you are breastfeeding, did you receive a copy of:
"Breastfeeding: Making It Work?" Yes No
"Breastfeeding and Child Care: What Moms Can Do?" Yes No

TO BE COMPLETED BY PARENT

At home, my baby drinks (check all that apply):

- Mother's milk from (circle)

  Mother bottle cup other
- Formula from (circle)

  bottle cup other
- Cow's milk from (circle)

  bottle cup other
- Other: _____from (circle)

  bottle cup other

How does your child show you that s/he is hungry?

How often does your child usually feed?

How much milk/formula does your child usually drink in one feeding?

Has your child started eating solid foods?

If so, what foods is s/he eating?

How often does s/he eat solid food, and how much?

TO BE COMPLETED BY TEACHER

Clarifications/Additional Details:

At home, is baby fed in response to the baby's cues that s/he is hungry, rather than on a schedule?

Yes No

If NO,

- I made sure that parents have a copy of the "Infant Feeding Guide" or "Breastfeeding: Making it Work"
- I showed parents the section on reading baby's cues

Is baby receiving solid food? Yes No

Is baby under 6 months of age? Yes No

If YES to both,

- I have asked: Did the child's health care provider recommend starting solids before six months?

  Yes No

If NO,

- I have shared the recommendation that solids are started at about six months.

Handouts shared with parents:

Child's name: _____ Birthday: _____
m m / d d / y y y y

Tell us about your baby's feedings at our center.
I want my child to be fed the following foods while in your care:

	Frequency of feedings	Approximate amount per feeding	Will you bring from home? (must be labeled and dated)	Details about feeding
Mother's Milk				
Formula				
Cow's milk				
Cereal				
Baby Food				
Table Food				
Other (describe)				

I plan to come to the center to nurse / feed my baby at the following time(s): _____

My usual pick-up time will be: _____

If my baby is crying or seems hungry shortly before I am going to arrive, you should do the following (choose as many as apply):
__ hold my baby __ use the teething toy I provided __ use the pacifier I provided
__ rock my baby __ give a bottle of milk __ other Specify: _____

I would like you to take this action _____ minutes before my arrival time.

At the end of the day, please do the following (choose one):
____ Return all thawed and frozen milk / formula to me. _____ Discard all thawed and frozen milk / formula.

We have discussed the above plan, and made any needed changes or clarifications.

Today's date: _____

Teacher Signature: _____ Parent Signature _____

Any changes must be noted below and initialed by both the teacher and the parent.

Date	Change to Feeding Plan (must be recorded as feeding habits change)	Parent Initials	Teacher Initials

CAROLINA GLOBAL BREASTFEEDING INSTITUTE
Breastfeeding-Friendly CHILD CARE

In Collaboration With:
NC Department of Health and Human Services
NC Child Care Health and Safety Resource Center
NC Infant Toddler Enhancement Project