

# KANDY STRIPE ACADEMY

# Feeding Schedule -Infants

## To Be Completed for Infants Only

Child's Name: \_\_\_\_\_ Gender: \_\_\_\_\_ Birth date: \_\_\_\_\_

This form must be completed at the time of enrollment for all infants ages 0 to 24 months. It is the responsibility of the parent to update this form if necessary.

Please circle all applicable items regarding feeding:

Child Drinks from: 1. Bottle 2. Cup 3. Both

Child Drinks: 1. Formula 2. Milk 3. Juice

Child Eats: 1. Baby food 2. Table food 3. Both

### Feeding Schedule for Liquids:

On Demand \_\_\_\_\_ AM \_\_\_\_\_ AM \_\_\_\_\_ AM \_\_\_\_\_ PM \_\_\_\_\_ PM \_\_\_\_\_ PM

### Feeding Schedule for Solids:

On Demand \_\_\_\_\_ AM \_\_\_\_\_ AM \_\_\_\_\_ AM \_\_\_\_\_ PM \_\_\_\_\_ PM \_\_\_\_\_ PM

### How does child like to be fed:

In Lap \_\_\_\_\_ Infant Seat \_\_\_\_\_ High Chair \_\_\_\_\_ At Table \_\_\_\_\_

Any special feeding problems? \_\_\_\_\_

Any food allergies? \_\_\_\_\_

Any other allergies? \_\_\_\_\_

### Additional Information for

Does Child Use a Pacifier \_\_\_\_\_ Suck Thumb \_\_\_\_\_

Does Child Sit Up \_\_\_\_\_ Pull Up \_\_\_\_\_ Crawl \_\_\_\_\_ Use Walker \_\_\_\_\_

Walk With Support \_\_\_\_\_ Walk Alone \_\_\_\_\_

Are Bowel Movements Regular \_\_\_\_\_ Times Per Day \_\_\_\_\_

At What Times Usually \_\_\_\_\_

Any Problems With Diarrhea \_\_\_\_\_ Constipation \_\_\_\_\_ Colic \_\_\_\_\_ Sensitive Skin \_\_\_\_\_

Diaper Rash \_\_\_\_\_

Do You Prefer: Oil \_\_\_\_\_ Powder \_\_\_\_\_ Lotion \_\_\_\_\_ Other \_\_\_\_\_

Does your child have a "Fussy Time?" \_\_\_\_\_ When: \_\_\_\_\_

Does your child have a Playtime? \_\_\_\_\_ When: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# INFANT CARE INSTRUCTION SHEET

STANDARD 746.2421(CENTERS) 747.2321 (HOMES)

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Type of Formula (Be Specific): \_\_\_\_\_ Warmer? \_\_\_\_ Yes \_\_\_\_ No

Type(s) of Juice: \_\_\_\_\_

Type of Diet: Cereal \_\_\_\_\_ Meats \_\_\_\_\_

Vegetables \_\_\_\_\_ Fruits \_\_\_\_\_

\_\_\_\_\_

Allergies: Food: \_\_\_\_\_

Skin: \_\_\_\_\_

Other: \_\_\_\_\_

Symptoms Produced: \_\_\_\_\_

Skin Care: Ointment: \_\_\_\_\_ Special Soap: \_\_\_\_\_

Sleeping Position: \_\_\_\_ On Back \_\_\_\_ On Stomach or \_\_\_\_ On Side (Dr. Approval Required)

Does your Baby use a Pacifier? \_\_\_\_ Yes \_\_\_\_ No

Other Helpful Information: (Please include schedule for feeding, sleeping, etc.)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Parent's Signature Date

\_\_\_\_\_  
Parent's Signature Date

\_\_\_\_\_  
Parent's Signature Date

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Parent's Signature Date

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Parent's Signature Date

\_\_\_\_\_  
Parent's Signature Date

\*NOTE: Please update this form as changes are made. Parents please re-sign and re-update this form every 30 days from date of last signature.\*