

Infant Feeding Schedule

My child drinks breast milk only: _____

My child is on formula: _____

Please tell us the name of the formula: _____

If your infant is only on bottles and no solids (baby food) you can list the range of time between bottles (ex: every 2-3 hours) and the amount of ounces per bottle.

If your infant is on solids (baby food) and bottles please write the estimated times you wish your child to get his/her bottles and the times you wish your child to get solids.

Time Range:

What your child eats:

Time Range:	What your child eats:

Sleep Schedule

Additional Comments: _____

Please state if you wish for your child to be woken when sleeping, for a feeding.

Parent Signature: _____

Date: _____