

Infant's Schedule and Information

Infant's Name: _____ Birthday: _____

Mom's first name: _____ Dad's first name: _____

Cell Phone # _____ Hand Held Radio Channel: _____

Daily Schedule

Bottles (circle one)	Formula	Whole Milk					Breast Milk				
	Ounces/Amount	AM					PM				
Milk		8	9	10	11	12	1	2	3	4	5
Juice		8	9	10	11	12	1	2	3	4	5
Cereal		8	9	10	11	12	1	2	3	4	5
Fruit		8	9	10	11	12	1	2	3	4	5
Veggies		8	9	10	11	12	1	2	3	4	5
Other		8	9	10	11	12	1	2	3	4	5
Finger Foods – small pieces graham crackers, cheerios, toast	Yes No										

Naps ? How long ? _____ 8 9 10 11 12 1 2 3 4 5

Special naptime routine ? _____

Allergies? _____

Special Instructions: _____
