Infant Diet Plan

Child's Name: _____Month:_____

Age: (in months) _____ Year: _____

Kind of Formula or Milk: _____

How many ounces and how often: _____

Baby Food: we provide, please circle the foods your child may have:

Green Beans Peas Carrots Squash Sweet Potatoes Garden Vegetables

Peaches Pears Applesauce Bananas Apples & Blueberries Apple & Mango Apple & Strawberry Rice Cereal Oatmeal Cereal

Puffs Little Crunchies Gerber Cookies Apple Juice Wagon Wheels

Breakfast Table Foods: we provide, please circle the foods your child may have:

Pancakes Waffles French toast English Muffins Toast Blueberry Muffins

Yogurt Cheerios Corn Flakes Rice Krispies Golden Grahams Life Cereal

Apple Juice Cottage Cheese Jelly

Snacks: we provide, please circle the foods your child may have:

Graham Crackers Saltine Crackers Cheese Yogurt Cheez-its Animal Crackers

Vanilla Wafers Blueberry Muffins Snack Mix Apple Juice Rice Krispie Treats

Foods your child may NOT have:

_____

Signature: _____ Nuk: Yes or No

The Department of Human Services requests that we obtain written dietary instructions from the parents of each infant every month.