

Individual Infant Meal Record with Meal Pattern

Child's Name:		Facility:	
Age:	DOB:	Completed By:	
Formula:		Parent Provides: Formula YES__ NO__ Food YES__ NO__	
Medical Statement on file? YES__ NO__			

Breakfast	Age 0-5 Mo.	Age 6-11 Mo.	Date: Monday	Date: Tuesday	Date: Wednesday	Date: Thursday	Date: Friday
Formula, Breast Milk	4-6fl oz	6-8fl oz					
Fruit and / or Vegetable		0-2 Tbsp					
Choose one of the following:							
Cheese; Infant cereal, meat, fish, poultry, whole egg, cooked or dry bean/peas ; Cottage Cheese; Yogurt		0-2 oz					
		0-4 Tbsp					
		0-4 oz/ ½ c					
		0-4 oz/ ½ c					

Lunch or Supper	0-5 Mo.	6-11 Mo.	Monday	Tuesday	Wednesday	Thursday	Friday
Formula or Breast Milk	4-6fl oz	6-8fl oz					
Fruit and/or Vegetable		0-2 Tbsp					
Choose one of the following:							
Cheese; Infant cereal, meat, fish, poultry, whole egg, cooked or dry bean/peas; Cottage Cheese; Yogurt		0-2 oz					
		0-4 Tbsp					
		0-4 oz/ ½ c					
		0-4 oz/ ½ c					

Supplement / Snack	0-5 Mo.	6-11 Mo	Monday	Tuesday	Wednesday	Thursday	Friday
Formula or Breast Milk	4-6fl oz	2-4fl oz					
Fruit and/or Vegetable		0-2 Tbsp					
Choose one of the following:							
Slice Bread Crackers Infant or Ready-to-Eat Breakfast Cereal		0-1/2 sl					
		0-2 each					
		0-4 Tbsp					

Place and asterisk (*) beside any component provided by the parent/guardian