

Provider's Name \_\_\_\_\_ Week of: \_\_\_\_\_

Child No. 1: \_\_\_\_\_ Age: \_\_\_\_\_ Formula: \_\_\_\_\_ Cereal \_\_\_\_\_

**BIRTH THROUGH 3 MONTHS** List amounts of food offered to infants, not amount consumed.

MEAL REQUIREMENTS		AMOUNTS	MON.	TUES.	WED.	THURS.	FRI.
BRK	I.F.I.F. or Breast Milk*	4-6 fl. oz					
AM	I.F.I.F. or Breast Milk*	4-6 fl. oz					
LUN	I.F.I.F. or Breast Milk*	4-6 fl. oz					
PM	I.F.I.F. or Breast Milk*	4-6 fl. oz					
SUP	I.F.I.F. or Breast Milk*	4-6 fl. oz					
EVE	I.F.I.F. or Breast Milk*	4-6 fl. oz					

Child No. 2: \_\_\_\_\_ Age: \_\_\_\_\_ Formula: \_\_\_\_\_ Cereal \_\_\_\_\_

**BIRTH THROUGH 3 MONTHS** List amounts of food offered to infants, not amount consumed.

MEAL REQUIREMENTS		AMOUNTS	MON.	TUES.	WED.	THURS.	FRI.
BRK	I.F.I.F. or Breast Milk*	4-6 fl. oz					
AM	I.F.I.F. or Breast Milk*	4-6 fl. oz					
LUN	I.F.I.F. or Breast Milk*	4-6 fl. oz					
PM	I.F.I.F. or Breast Milk*	4-6 fl. oz					
SUP	I.F.I.F. or Breast Milk*	4-6 fl. oz					
EVE	I.F.I.F. or Breast Milk*	4-6 fl. oz					