



THE SITTER INC.

INFANT FEEDING SCHEDULE

Name _____

Date _____

Do I drink formula? _____

Breast milk _____

Name of formula _____

How often do I eat? _____

What amount? _____

Do I eat food? Yes _____ No _____

What do I eat? Table food _____

Baby food _____

How often do I eat? _____

What Amount? _____

Parent signature _____

Date _____