

Monthly Infant Care Instructions

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Allergies/Special Needs: \_\_\_\_\_

**Breast Milk/Formula**

How often? \_\_\_\_\_

Amount: \_\_\_\_\_

**Juice** Yes No

How often? \_\_\_\_\_

Amount: \_\_\_\_\_

**Water** Yes No

How often? \_\_\_\_\_

Amount: \_\_\_\_\_

**Cereal** Yes No

How often? \_\_\_\_\_

Amount: \_\_\_\_\_

**Jar Foods**

Fruits Yes No

Veggies Yes No

Meats Yes No

How often? \_\_\_\_\_

Amount: \_\_\_\_\_

**Notes:** \_\_\_\_\_

**Other information:** Pacifier Yes No

Diaper Ointment Powder Lotion

Yes No Yes No Yes No

\*\*\*Your child will be placed on his/her back for sleep unless we receive a note from a physician stating otherwise.

This form must be updated every 30 days or as changes occur. If changes need to be made, please request a new form from management. Review this form and if no changes/updates need to be made please sign and date below.

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

